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Bereavement and mental illness

Part 1. A clinical study of the grief of bereaved psychiatric patients

By C. MURRAY PARKES*

Of all the functional mental disorders almost the only one whose cause is known, whose symptomatology is stereotyped and whose outcome is usually predictable is grief. That grief is a mental disorder there can be no doubt, since it is associated with all the discomfort and loss of function which characterize such disorders. The fact that it is usually transient and seldom treated by psychiatrists is irrelevant to this issue: a bruise or a burn does not cease to be pathological just because it is treated at home. (For a clear discussion of this point of view Engel's paper 'Is grief a disease?' (1961) should be read.)

Because grief is the typical response to bereavement, however, it does not follow that it is the only type of disorder which may occur and there are a large number of other psychiatric and somatic conditions which have been attributed to bereavement.

In a previous article (Parkes, 1964) it was shown that the number of patients admitted to a psychiatric clinic whose presenting illness had come on within six months after the death of a spouse was six times greater than would have been expected had the bereavement not been a causative factor in the illness which followed it. The diagnosis attributed to these and other bereaved psychiatric patients covered a wide range but 65 % (61 out of 94) fell within the category of Affective Disorders (a significantly larger proportion than in the non-bereaved clinic population).

Among reports of patients attending psychiatric clinics following bereavement the majority have been said to be suffering from atypical or complicated forms of grief. These have been called 'morbid grief reactions' but this is like calling a septic wound a 'morbid wound reaction'. Grief *is* a reaction and is also, because it leads to dysfunction, morbid or pathological. Rather more satisfactory are the terms employed by Engel. He completes the analogy to a septic wound by speaking of 'complications' of grief and in the present study the terms complicated grief and atypical grief will be used interchangeably. Few attempts, however, have been made to establish systematically how closely these atypical forms resemble the usual response to bereavement.

This is the first of two articles in which a study of recently bereaved adult psychiatric patients is reported and an attempt is made to systematize the various types of reaction which follow a major bereavement.

In this article the case material will be considered in the light of studies of the behaviour of bereaved 'normals'. Figures will be presented to show the incidence of the principal features exhibited and these features will be described.

In the second article the data will be supplemented by reference to other studies of bereaved psychiatric patients and a classification of bereavement reactions will be put forward.

No attempt will be made in these papers to relate the findings to contemporary theories of the psychopathology of grief. This is so complex and contentious a field that it is not possible to do justice to it in the space available. Similarly, this is not the place to consider the many antecedent and concurrent variables which may influence the type and intensity of the response to bereavement. These issues, which are not strictly relevant to a descriptive study, will be discussed elsewhere.

* Research Psychiatrist, Tavistock Institute of Human Relations, Beaumont Street, London, W. 1. Formerly at the Institute of Psychiatry, Maudsley Hospital, London, S.E. 5.

METHOD

The study was carried out with patients attending the Bethlem Royal and Maudsley Hospitals whose presenting symptoms had come on during the terminal illness or within six months after the death of a parent, spouse, sibling or child.

Data were obtained from two series of patients:

(*a*) *The interview series* consisted of twenty-one patients (three out-patients and eighteen in-patients) who were brought to the notice of the investigator by members of the hospital staff during the years 1958–60 (six others were not included because they refused, or were too ill to give a detailed account of their reaction to the bereavement). Each of these patients was interviewed by the writer and additional information was obtained from the case notes. At the interview the patient was encouraged to talk freely about the dead person and the bereavement, and questions were asked, when necessary, to supplement the information given. A full record of each interview was kept along with a summary of the history from the case notes and data were codified in accordance with a check-list of information to be obtained from each case. Whenever the information obtained at the interview was insufficient a second and sometimes a third interview with the patient was carried out. Even though they found the interview disturbing most patients were glad of the opportunity to discuss the loss which still monopolized their thoughts.

(*b*) *The case-note series*. Information was obtained from the case notes of a further ninety-four bereaved patients admitted during 1949–51 and using the same criteria for inclusion of cases. Numerical data from these notes have been published already (Parkes, 1964). In only twenty-eight of these cases did the notes give an adequate account of the patient's reaction to his bereavement and material from this sample will be used only for illustrative purposes. Unless otherwise stated, therefore, all figures given in this article refer to the twenty-one patients included in the interview series.

THE TYPICAL REACTION TO BEREAVEMENT

Complicated and uncomplicated forms of grief were distinguished by Lindemann (1944) who set up a clinic for the relatives of people killed in the Coconut Grove night-club fire and subsequently added to these from his psychiatric practice. He gives an anecdotal account of his findings in 101 cases of 'acute grief' and distinguishes between the 'normal syndrome' and 'distorted pictures' which resembled the normal.

The main drawback of this and several other studies is the lack of a clear account of 'normal' or 'uncomplicated' grief. The patients attending Lindemann's clinic were clearly not a representative sample of bereaved people and he does not state his criteria of 'normality'. More informative in this respect is the study of Marris (1958) who was able to interview in their homes seventy-two out of 104 unselected widows living in East London whose names he had traced through the death registrations of their husbands. They were all young or middle-aged women (mean age 42 years, range 25–56) and were seen on average 2 years after the bereavement. The preponderance of middle-aged widows in the present study and in another by Wretmark (1959), however, suggests that women under 60 who lose their husbands are particularly liable to have complicated reactions and it may be that Marris has described an unusually severe form of grief. Nevertheless, no other author gives so detailed and systematic an account of the course of grief and Marris is able to give figures for the relative frequency of the different features which he describes so that it is possible at least provisionally, to distinguish typical and less typical ones. Other features of grief have been described by Waller (1951) who derives information from an unstated number of cases seen in his work as a sociologist and by Bozeman, Orbach & Sutherland (1955), who described the anticipatory grief of twenty mothers of children with leukaemia when they realized that the prognosis was hopeless.

From these studies can be derived a description of typical, uncomplicated grief which will be used as a yardstick in determining the typicality of the features which occurred among the psychiatric patients studied here.

The typical reaction to bereavement varies with the closeness of the relationship with the deceased. When the dead person is of first-

order kin to the survivor and there has been at least a moderate amount of social interaction between them during the year preceding the death then the reaction can be expected to take the following form:

At first the full reaction may be delayed or there may be a period of numbness or blunting in which the bereaved person acts as if nothing had happened for a few hours or days up to 2 weeks.* Thereafter attacks of yearning and distress with autonomic disturbance begin. These occur in waves and are aggravated by reminders of the deceased. Between attacks the bereaved person is depressed and apathetic with a sense of futility. Associated symptoms are insomnia, anorexia, restlessness, irritability with occasional outbursts of anger directed against others or the self, and preoccupation with thoughts of the deceased. The dead person is commonly felt to be present and there is a tendency to think of him as if he was still alive and to idealize his memory. The intensity of these features begins to decline after 1–6 weeks and is minimal by 6 months, although for several years occasional brief periods of yearning and depression may be precipitated by reminders of the loss (e.g. at anniversaries). The features are not typically so severe that they cause the patient to seek help from a psychiatrist, miss more than a fortnight's work, attempt suicide, or isolate himself to such a degree that he becomes inaccessible to relatives and friends.

One aspect of this description of typical grief which is in doubt is its duration. Lindemann (1944) found that in the patients seen by him successful resolution occurred in 4–8 weeks but Marris (1958) thinks that, in young widows at any rate, some features may persist 'for months or even years'. For the purposes of this study an arbitrary upper limit of 6 months has been taken, but further investigation is needed to establish the range of variation of the duration of grief in normal populations. Most of the patients whose grief was rated as 'prolonged' in the present study had reactions lasting considerably longer than 6 months.

* Two weeks is an estimate. No figures exist to show how long numbness usually lasts.

Results

Table 1 gives basic information about the composition of the interview series. It shows the age, sex, marital status and occupation of each patient at the time of the loss; the kinship of the dead person and the mode and cause of his death.

It will be seen that there were twenty-one patients included in the interview series. Only four of these were men and all four were married at the time of their bereavement. Among the seventeen women thirteen were married.

The mean age of the men was 44·2 years (range 34–67 years) and of the women 46·7 years (range 12–69 years). Eight of the female patients were housewives without other occupation and most patients were from occupational classes III and IV. Nine of the bereavements resulted from the death of a spouse, five from the death of a mother, two a father, four a sibling and one a child.

Owing to the method of selection some doubt may be expressed whether the patients in the interview series constitute a representative sample of bereaved psychiatric patients admitted to the joint hospitals. In point of fact on most relevant features there was much resemblance between them and the ninety-four bereaved patients in the case-note series. Thus they both contained a preponderance of women (seventeen out of twenty-one in the interview series, sixty-five out of ninety-four if the case-note series), the mean age was similar (48·8 years in the interview series, 46·5 in the case-note series) and the commonest kin to be lost was a spouse (nine out of twenty-one in the interview series and thirty-two out of ninety-four in the case-note series). On the other hand, there were a number of patients in the case-note series whose bereavement seemed to have little to do with the psychiatric illness which followed it, whereas in the interview series it will be shown that in only one patient was this so. It seems likely, therefore, that patients whose illness was most clearly

Table 1. *Basic information concerning bereaved psychiatric patients (interview series only)*

Case	Sex of patient	Age of patient	Marital status of patient at time of loss	Occupation of patient at time of loss	Kinship of deceased person	Termination	Cause of death
A	M	34	M	Cinema projectionist	Wife (and mother)	G*	Malignant melanoma
B	F	64	M	Housewife (H-W)	Husband	S	Coronary thrombosis
C	F	48	M	Shop assistant	Husband	G	'Stroke'
D	F	50	M	Waitress	Sister	S	'Stroke'
E	F	35	M	H-W	Daughter	S	Cardiac catheterization
F	F	56	M	H-W	Husband	S	'Stroke'
G	M	67	M	Retired chief instructor (trams)	Wife	S	Asthma
H	F	56	M	Kitchen help	Husband	G	Bronchial carcinoma
I	F	57	S	Clerk	Sister	G	Pancreatic carcinoma
J	F	49	M	H-W	Husband	S	Coronary thrombosis
K	F	54	S	Typist	Mother	G	Old age
L	M	38	M	Engineering fitter	Father	G	Bronchial carcinoma
M	F	30	M	H-W	Mother	S	Coronary thrombosis
N	F	12	S	School girl	Mother	S	Mammary carcinoma
O	F	69	M	H-W	Husband	G	Bronchial carcinoma
P	F	30	M	Clerk	Brother	R	Accident
Q	F	55	M	H-W	Brother	R	Bladder haemorrhage
R	F	26	S	Nurse	Mother	G	Bronchial carcinoma
S	F	68	M	H-W	Husband	S	Coronary thrombosis
T	F	35	M	Secretary	Father	S	Coronary thrombosis
U	M	38	M	R.A.F. officer	Mother	R	Fractured femur

* G = gradual termination (more than 7 days); R = rapid termination (1–7 days); S = sudden termination (within 1 day).

related to their bereavement were more often brought to the attention of the writer than patients whose illness was only incidental. This bias in the method of selection of cases was absent in the case-note study.

In the main study it was found that only one patient out of twenty-one had had a reaction which fell within the limits of the typical reaction which has been described. In all the rest the typical reaction was in some way distorted or exaggerated and it was this distortion or exaggeration which caused the patient to be regarded as mentally ill. In order to determine the extent and nature of this distortion it is necessary to consider both the similarities and differences between the clinical pictures shown by the psychiatric patients studied and the typical picture which has been described. Fortunately figures are given by Marris for the frequency of symptoms in his series of randomly selected widows and it seems reasonable to conclude that the features found most frequently by him are those most characteristic of 'uncomplicated' or 'typical' grief. It does not follow that all the reactions which he observed were 'typical', in fact it is

very probable that those symptoms which were found infrequently by Marris and significantly more frequently among our psychiatric patients should be regarded as atypical and as indicating a relatively more complicated reaction.

Since the patients studied here covered a wider age range than Marris's and included male patients, they are not strictly comparable. For purposes of statistical comparison, therefore, a subsample of fourteen patients from the interview study were matched with the widows studied by Marris for age and sex.

Table 2 shows the results of comparing the incidence of the features which he enumerated with the incidence of the same symptoms in the matched subsample.

none was found less frequently. Thus all the patients were depressed and/or anxious and a majority of both series were apathetic and socially withdrawn, slept badly and had a sense of the persisting presence of the dead person. Less common features, but found with similar frequency in both groups were 'deliberate cultivation of the idea of the persisting presence of the dead person', 'execution of actions previously associated with the dead person' and 'attempts to escape from reminders of the death'.

On the other hand there were three features which were found more frequently among the psychiatric patients and two of these differences in incidence reached statistical significance when Marris's patients were compared

Table 2. *Incidence of features of grief in non-psychiatric and psychiatric bereaved women under* 60

Principal features of grief reported	Numbers		Percentages	
	Unselected widows (Marris) (*n*)	Matched subsample (Parkes) (*n*)	Unselected widows (Marris) (%)	Matched subsample (Parkes) (%)
Depression or anxiety	72	14	100	100
Apathy	44	7	61	50
Insomnia	57	10	79	71
Cultivation of idea of presence	15	3	21	21
Sense of presence of deceased	36	7	50	50
Execution of acts associated with deceased	15	3	21	21
Attempts to escape reminders	13	5	18	36
Difficulty in accepting loss	17	11	23	79*
Blames self	8	11	11	79*
Blames others	11	6	15	43
Total	72	14	100	100

* $P < 0{\cdot}001$.

The matched subsample can be taken as representative of the interview series as a whole since the incidence of the symptoms shown was very similar in both.

Most of the features for which Marris gives figures were found with similar frequency among the bereaved psychiatric patients, and with the matched subsample. Thus a quarter of Marris's patients and two-thirds of the psychiatric patients were thought to have had 'difficulty in accepting the fact that the lost person was dead' (χ^2 27·2, 1 D.F., $P < 0{\cdot}001$) and similar proportions expressed 'ideas of guilt and self blame' (χ^2 13·7, 1 D.F., $P < 0{\cdot}001$).

Also more frequent in the psychiatric group was 'hostility towards others associated with the loss' but the difference was small and did not reach statistical significance.

psychiatric patients is compared with the description of typical grief which has been given. The results of this comparison are shown in Table 3.

Table 3. *Atypical features of grief of bereaved psychiatric patients (interview series only)*

Case	Prolonged grief	Intensified grief	Persisting self-blame	Persisting difficulty in accepting loss	Delay > 2 weeks	Symptoms of last illness of deceased	Panic attacks	Other symptoms
A	+	+	+	+	+	.	+	Urticaria
B	+	+	+	+	+	.	.	Three episodes of elation
C	+	+	+	+	+	.	.	.
D	+	+	+	+	+	.	.	.
E	+	+	+	+	.	.	.	Headaches, histrionic outbursts
F	+	+	+	+	.	+	+	.
G	+	+	+	.	.	.	.	.
H	+	+	.	+	.	+	+	.
I	+	.	+	+	+	.	.	.
J	+	+	+	+	+	.	.	.
K	+	.	+	+	.	.	+	Obsessions and compulsions
L	+	.	.	+	.	+	.	.
M	+	.	+	+	.	.	.	Compulsive laughter
N	+	.	.	+	.	+	.	.
O	+	.	.	.	+	.	.	Phobia of cancer
P	?	+	+	+	.	.	.	Headaches
Q	?	+	+	.	.	.	.	.
R	?	.	+	.	+	.	+	.
S	?	+	.	.	.			.
T	.	+	.	.	.	+	+	Histrionic outbursts
U	.	.	.	.	.	.	.	Hypochondriacal depression
Totals out of 21	15	13	14	14	8	5	6	.

? Grief still present when interviewed within 6 months of bereavement.

Other differences become apparent when the magnitude and duration of the symptoms are taken into account and the grief of the

This shows the way in which the grief of each individual patient in the interview series differed from the typical picture. The two

symptoms 'self blame' and 'difficulty in accepting the fact of loss' are included because, as has been shown, they were found with exceptional frequency among the psychiatric patients studied (this does not mean that they may not occur in minor or transient form in the typical reaction). The 'other psychiatric symptoms' listed include all those major symptoms suffered by these patients which do not resemble some aspect of grief.

It will be seen that in most cases the reaction to bereavement is prolonged regardless of other symptoms and there is a tendency for 'self-blame', 'difficulty in accepting the fact of loss' and 'delay' to be associated together (eleven out of fourteen patients with 'difficulty in accepting the fact of loss' also had 'ideas of guilt', seven out of eight patients with 'delayed reaction' also had 'difficulty in accepting the fact of loss'). 'Acquisition of symptoms resembling those suffered by the deceased in his last illness', however, is negatively associated with 'delay', the two never occurring in the same patient (unfortunately the figures are too small to allow this trend to be tested by statistical means). 'Intensification of grief' and 'panic attacks' do not seem to be particularly associated with any one type of reaction.

In no case was the grief briefer than usual, less intense than usual or permanently absent. When the patients in the case-note series were examined in the same way very similar results were obtained but there were rather more delayed reactions and patients whose psychiatric disorders did not resemble grief.

Each of the features mentioned will now be considered in more detail.

Duration. The difficulty in establishing the duration of typical grief has already been mentioned and in this study an upper limit of 6 months has been taken. Fifteen patients (71 %) had reactions longer than this. These figures are minimal since six patients were still severely disturbed by their grief at the time the investigation ended and four of them had not yet been bereaved for more than 6 months. If these four patients are excluded from consideration then 89 % (15/17) of the reactions were prolonged. In eleven cases the reaction had lasted a year or more and in six it had lasted for more than 2 years (the longest being 6 years). Among those patients whose symptoms disappeared or at least made a marked improvement the total time from bereavement to improvement averaged 18 months. In no case was the reaction clearly briefer than the usual.

Intensity. Whilst measures of intensity are difficult to make, it was clear that thirteen of the patients studied had become severely disturbed and that this disturbance had persisted long after any acute upset would normally have subsided. Eight patients cried uncontrollably and several others said they felt 'too hurt to cry'. Agitated and aggressive outbursts occurred in four cases and four admitted suicidal preoccupations. The intensity of grief impaired the capacity for work (eight cases) and caused many to shut themselves up at home or withdraw in some way from contact with their friends and relatives (fifteen). Four patients, in speaking of the intensity of their grief emphasized feelings of internal loss: 'something died in me'. In no case was the grief, when it occurred, less intense than expected.

The immediate reaction. In half the patients studied (eleven) the earliest reaction to the loss was a *sense of numbness.* This was variously described as 'a dazed feeling', 'blunted', or 'stunned'. All emotional reaction was diminished and patients said they 'had no feelings at all', 'couldn't cry', 'no feeling about anything', or were 'cold', 'drained of all emotion', 'automatic'. There was often a conscious feeling of something being 'pent-up' or inhibited; patients felt 'all stewed up inside' and one said: 'When he died something died in me' and associated this with her inability to cry; another said, 'Part of me stopped living'. The numbness somehow protected them from a full realization of the loss, 'I couldn't realize what had happened'. Another patient 'took it inwardly' and another felt 'protected from feeling unhappy'. The state

lasted from a few days to several months. It had affinities with states of depersonalization and one patient actually felt 'unreal' but this was exceptional.

It is uncertain whether or not this numbness should be regarded as a part of the typical reaction. Waller and Lindemann seem to regard it as such but Marris, who may well have come on the scene too late, does not mention it specifically; nevertheless, he quotes from an interview with a widow who had clearly suffered from it: 'Everything went blank, I was sort of dead for a fortnight.' What evidence there is suggests that numbness is a part of the typical reaction but does not normally last for more than a short time.

It is necessary to take the period of numbness into account in deciding whether or not the onset of grief was more than usually delayed. Two weeks was therefore taken as an arbitrary upper limit of the duration of numbness in typical grief. Eight patients in the present study are classed as having had *delayed reactions* by this criterion. Three of such reactions seemed to have developed after a prolonged period of numbness; in the remaining five patients there was, during the period of delay, very little emotional disturbance and even 'numbness' could not be established. Patients whose grief was delayed often played a leading role in making the funeral arrangements and setting an example to the rest of the family. One was described as 'a tower of strength' but more often relatives were suspicious of the apparent lack of affect and waited for the breakdown to occur.

Apart from the feeling of 'numbness' several patients showed other symptoms during the period of delay. Thus one was unable to sleep although in other respects she seemed quite normal, another had panicky feelings when reminded of death or violence, and others expressed guilt or anger in relation to the loss or became socially withdrawn.

Associated with the numbness and delayed reactions was a pronounced *difficulty in accepting the fact that the dead person was really dead.* This has been mentioned by Marris, but its greater frequency in the psychiatric group where it was described by fourteen patients suggests that it may be more prominent in complicated than in uncomplicated reactions. It sometimes took the form of a complete refusal to accept the fact of death. Thus one patient, a woman of 66, refused to acknowledge that her son was dead and persuaded her husband to bring her from New Zealand to England in order to find him. On arrival she thought she saw her dead son on the stairs, thereafter she was able to cry for the first time and came to accept the fact of his death.

More often there was a partial, intellectual acceptance of the death but the patient pretended to himself that it had not occurred: 'I still only believe she's dead if somebody says so', 'I still think it hasn't happened, I'll wake up and he'll be there', 'I just didn't think of my mother as dead' or 'I just didn't want them to talk about it, because the more they talked the more they'd make me believe she was dead'.

The full reaction. When the patient eventually came to accept the fact of death he showed a picture which closely resembled the affective disturbance of typical grief. He became *depressed and anxious*, preoccupied with the memory of the dead person and *pining* for reunion with him. Severe distress of mind was produced by any *reminder of the deceased* and such reminders were both avoided and sought after. This ambivalence is exemplified by the patient who went to a Spiritualist meeting in the hope of being reunited with her dead husband but when told that he was in the room became very disturbed and refused to believe it. Another patient spent many hours lying on her bed playing with her dead child's toys but could not be persuaded to go out because she knew she would see other children and that would 'bring it all back'.

In six cases distress of mind produced by reminders of the death, loneliness or loss of support were so intense that *panic attacks* resulted. Attacks of breathlessness and 'choking sensations' at the time when a husband had previously come home from

work were typical; and panic attacks could sometimes be brought on by any reminder of death or violence.

Associated with the affective disturbance were *functional somatic symptoms* such as insomnia (fifteen cases), anorexia (thirteen) and loss of weight (eight). Patients were usually apathetic (eleven) and unable to initiate any useful activity (fifteen) so that they behaved in an aimless, listless manner. At the same time they were also alert, restless and hypersensitive as illustrated by a patient who put cotton-wool in her ears because everyday sounds were so intense and disturbing. All these symptoms have been described as part of the typical reaction.

So has *social withdrawal* which was apparent in fifteen cases. Withdrawal resulted partly from avoidance of sympathetic people who would remind the bereaved person of his loss, partly from an apathetic loss of outside interests and partly from feelings of anger and resentment. These feelings of *anger and resentment* were typically no more than a general irritability with and resentment of anyone who was not similarly bereaved (fourteen cases); 'I couldn't see any reason why it was done to me'. Exceptionally the anger was directed against some individual, usually doctors, nurses or clergy who had attended the dead person during his last illness (eight cases); as one patient put it: 'I still feel angry when I see a clergyman.' In another case it was the dead husband who was blamed for dying and leaving the patient, his second wife, on her own: 'He looked so happy in death, it made me think he was with her [his first wife]'. Alternatively, the anger was directed more generally against fate or God, who was held responsible (nine cases): 'If there was a God he wouldn't let anyone die on their own.'

It is uncertain what intensity of hostility is a part of typical grief. Marris's figures are inconclusive and it seems likely that a certain degree of irritability or anger is usual. There was one patient, in the present study, however, in whom this clearly reached pathological intensity and here the circumstances were exceptional. She was a woman of 43 whose favourite sister had been murdered by her brother-in-law. After the brother-in-law had been committed to Broadmoor she became preoccupied with the idea that she ought to smuggle in an axe and kill him. Severe depression followed, with guilt and suicidal ideas intermingled with aggressive outbursts. She did not improve until she underwent a rostral leucotomy 4 years later. She then remained well for a year until her brother-in-law was released from Broadmoor when her depression returned.

All of the eight patients who showed marked hostility to individuals connected with the death also expressed *ideas of guilt and self-blame* and there were six others who showed guilt without hostility. These self-reproachful ideas were usually connected with some minor omission which might have contributed to the death or made the last hours of the dead person less pleasant. Thus one patient blamed himself for not asking for a second opinion on his wife and another thought that her refusal to have sexual intercourse with her husband might have contributed to his death from a cerebral haemorrhage during the night. There is nothing intrinsically pathological about these symptoms but the fact that they were so much more frequent among the psychiatric patients than among Marris's widows coupled with the fact that in several cases guilt dominated the clinical picture suggests that this is a feature of particular importance in determining pathogenesis. In fact four patients were preoccupied with self-reproachful ideas which were the main reason for their being regarded as ill.

Memories, thoughts and perceptions were characteristically centred on the death and the dead person. The events leading up to the death were gone through again and again in fantasy and repeated attempts were made to explain how and why it had occurred. Chodoff, Friedman & Hamburg (1964) have spoken of the 'search for meaning' among the parents of children dying from neoplastic disease, but this behaviour is easier to under-

stand if we think of it as a sophisticated form of the '*search for the lost object*' which is a part of the attachment behaviour of all social animals. Further discussion of this issue, however, must take place in a later article.

Usually memories of the dead had a nostalgic, bitter-sweet quality and the dead person tended to be *idealized* (eight cases). Several patients (five) in this study *deliberately cultivated the idea of the dead one's presence* by imagining him speaking to them, or in one case by lying on the bed of her dead child and playing with his toys. Others (five) habitually executed actions *previously directed towards the dead person*, such as going to the street door to look for her husband when he was due back home from work or rocking the empty cradle of a dead baby. Half of the patients (eleven) had a *sense of the continued presence of the dead person*, as if he was still about the house: 'I think he's there and it's wonderful, then I wake up and find he's not there, there's the void.' This sense of presence was sometimes augmented by *illusions or hallucinations* (eight cases). Knocks or creaks were thought to indicate the presence of the dead person, or a shadow would be identified as his. One patient, when sitting in a chair, would seem to feel her husband playing with her ear and hear his voice saying, 'just rest'. Several heard themselves called, and one said: 'I used to feel that she'd called me—then I'd realize that she hadn't and it'd hit me.'

These illusions, thoughts and memories were often pleasant and conform well to the descriptions of similar features given by Marris's widows. Sometimes, however, they acquired an unpleasant quality and were occasionally quite terrifying.

They were sometimes associated with *vivid mental images* with a horrific quality (four cases). These occasionally amounted to hallucinations as in the case of a woman who kept seeing the mutilated face of her dead brother: 'As if someone suddenly puts a slide on.' Another woman sat for hours in the cemetery brooding over a clear memory of her dead baby with its glazed eyes and dry mouth. Yet another repeatedly awoke at night with a clear visual image of her dead child's face before her and heard him scream.

Unpleasant memories and perceptions have been mentioned by Marris and it seems likely that they occur in the typical picture. What distinguishes the patients described above, however, is the peculiar intensity and duration of them.

Identification with the dead person is regarded by Freud as an essential part of the process by which libido is detached and symptoms attributable to it have been called by Wretmark (1959) '*Phenomena of Identification*'. In the present study they were shown by five patients and usually took the form of symptoms resembling those suffered by the dead person during his last illness. In one case (case L), however, the feeling of identification was more general. This was in a man of 38 who, two years after the death of his father, was still depressed and preoccupied with his memory. With reference to his father he said: 'I'm just like him. I even have some of his habits. I often sit like him at table . . . I feel like him as I walk along. I get into his walk.' The patient demonstrated how he sticks his thumb between his teeth just as his father used to do. He was puzzled to observe that he dislikes doing these things.

Symptoms resembling those suffered by the dead person during his last illness were most commonly aches and pains similar in distribution to those of the deceased but in several cases classical hysterical symptoms occurred. Typical of the former type of case was a man of 42 who had 'modelled' himself on his father. After the father died from a coronary thrombosis he remained depressed for 3 months. He then seemed to be improving when he started to have pains in the left side of his chest with palpitations and became convinced that he too had heart disease. He improved with psychotherapy but shortly afterwards, following a dental extraction, he developed a pain in the groin and became convinced that he had had a mesenteric thrombosis, another condition from which his father

had suffered. When this was pointed out to him he again improved and remained well but for occasional mild hypochondriacal symptoms. Another patient, an unmarried woman of 29, developed a dull pain in her chest 4 months after the death of her father from a bronchial carcinoma. The pain closely resembled that which her father had experienced and was brought on by eating peanuts; he had often given her peanuts in the past and she associated them with him. She too had modelled herself on her father and after his death had taken his place in the home, regarding her mother and sister as ineffectual. She worked at a veterinary clinic because it was a 'man's work' and father had 'loved animals more than humans'. One patient who did not seem to have modelled herself on the dead person was a woman of 56 who had nursed her husband during his last illness. He had had a cerebral vascular accident with hemiplegia and aphasia. Two months later he had a second stroke and was unexpectedly found dead by his wife. She immediately developed a complete aphonia which lasted for ten days and she did not weep during this time. She then became tearful and depressed, blaming herself for having been a burden to her husband and for not having a specialist to see him.

Conclusions

Thanks to our lack of knowledge of the detailed course of typical, uncomplicated grief it has not always been possible to determine if a particular feature exhibited by the patients studied here is a part of the usual reaction to bereavement or a morbid form of it. The overall conclusion, however, is clear. Whilst our patients had experienced each of the features of typical grief, in most cases the duration of certain of these features was atypical; not only was grief prolonged but aspects of it were unusually severe, the particular aspect varying from case to case. In no case was the grief briefer than usual and even if delayed the full reaction, when it occurred, was never briefer or less intense than in the typical picture.

The patients interviewed were a selected group but their symptoms resembled so closely those of a large proportion of the unselected bereaved psychiatric patients in the case-note series that it seems reasonable to conclude that atypical grief is a common cause of the admission of bereaved patients to the joint hospitals.

'Self-blame' and 'difficulty in accepting the fact of loss' play a more prominent part in the grief of the psychiatric patients than in the more typical reactions to bereavement which have been described, and 'identification phenomena' have not, so far, been described in a 'normal' population, but each of these probably has its 'normal' equivalent. For instance, bereaved persons often try to 'explain' an untimely death in terms of the behaviour of themselves or others, there is a pressing need to say 'why it happened', and excessive importance is commonly ascribed to trivial events and omissions. It is in this setting that ideas of guilt and self-blame arise. Similarly, 'difficulty in accepting the fact of loss' is not uncommon immediately after a bereavement when it may take the form of the 'numbness' which has been described. It is only when this persists for an unusual length of time that it can be regarded as pathological. Since identification plays so large a part in the psychoanalytic theory of grief it is surprising that 'identification phenomena' do not seem to have been described as a component of typical grief. Wives who took over the occupation of a deceased husband have been mentioned by Krupp (1964) as examples of 'constructive identification' but there is a lack of satisfactory evidence for the adoption of traits and mannerisms of the dead person in reports of bereaved persons whose grief is, in other respects, within normal limits. Further discussion of the significance of these findings for the psychopathology of grief must await a later article.

Reference has already been made to the previous study (Parkes, 1964) in which it was shown that whilst bereaved psychiatric patients are more likely to be diagnosed 'affective dis-

order' than non-bereaved patients there is no one diagnostic category in which most of them are placed. This is hardly surprising when we consider the range of symptoms which occur during the process of grief. Thus anxiety symptoms, depressive symptoms, phobic symptoms or hypochondriacal symptoms may each be prominent at different times and enable a procrustean clinical diagnosis to be made. The recognition of the grief symptoms, however, is not difficult and since 'grief' is an aetiological diagnosis as well as a symptomatic one it is likely to prove more useful than the Krapelinian labels which are more usually employed.

But grief may take a variety of forms and it is not the only condition which may follow bereavement. Before proceeding further with the examination of these issues it is necessary to compare the results of this study with the results of other studies of bereaved psychiatric patients and this will be done in Part 2.

Summary

1. In this article is described the grief of 115 psychiatric patients (twenty-one of them interviewed by the writer) whose presenting illness had come on within 6 months of the death of a spouse, parent, sibling or child.

2. A matched subgroup of the patients interviewed were compared with the unselected widows studied by Marris. It was shown that most of the features of grief described by him were found with similar frequency in the bereaved psychiatric patients and two 'difficulty in accepting the fact of loss' and 'ideas of self-blame' were significantly more frequent in the psychiatric group.

3. Despite this all save one of the patients interviewed were suffering from atypical forms of grief. The atypical features, in order of frequency were; abnormal prolongation of grief, unusually intense grief, delayed grief, hypochondriacal symptoms resembling those suffered by the deceased during the last illness and panic attacks related to reminders of loss or death.

4. It is concluded that persons developing mental illnesses after bereavement commonly exhibit symptoms which differ in intensity and duration but not in kind from the features of typical grief.

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Bereavement and mental illness

Part 2. A classification of bereavement reactions

By C. MURRAY PARKES

This is the second of two articles in which the reaction to bereavement of 115 psychiatric patients (twenty-one of whom were interviewed by the writer) are studied. All of these patients came to the Bethlem Royal or Maudsley Hospitals with psychiatric illnesses which had come on within 6 months of the death of a parent, spouse, sibling or child. In Part 1 it was shown that all save one of the patients interviewed (the interview series) were suffering from atypical forms of grief. Comparison with studies of unselected bereaved 'normals' revealed that in our study, whilst none of the principle features of typical grief was permanently absent, these features might be prolonged or delayed or particular aspects of them exaggerated.

These findings will here be related to the results of earlier studies and a classification of bereavement reactions will be attempted.

In the present state of our knowledge it is not possible to make a comprehensive classification of all the varieties of reaction to loss which may occur. Bereavement is a common stress and only a small proportion of those who suffer it are referred to a psychiatrist. Thus there may be many reactions to bereavement which have not yet been reported and we must be content with trying to derive a framework into which can be fitted those cases which come to our notice.

In reviewing the literature, most of which comes from psychiatric practice, the first impression is of a bewildering variety of reactions; these range from ulcerative colitis to mania, and from leukaemia to hysteria. One is tempted to think that there may be nothing specific about bereavement as a stressor and that the reaction to it may be entirely determined by the personality and predisposition of the bereaved. That this is not the case, however, is evident since grief and its variants all represent highly specific forms of response. They contrast with other more varied and non-specific responses and give rise to our first main subdivision of Bereavement Reactions into:

I. The stress-specific grief response and its variants.

II. Non-specific responses.

The former occur only in response to the loss of a love object, but clinical evidence suggests that the latter can follow a variety of stressors or can even, in some cases, occur spontaneously. Moreover, whilst grief is the usual response to loss and its absence is indicative of psychopathology, the non-specific responses to be described are exceptional and are found in only a minority of cases.* This second subdivision, therefore, must be regarded as a mixed category in which grief, or one of its variants, is complicated by a non-specific reaction which may well be the main reason for the patient seeking help.

Differentiating reactions in this way helps to clarify our thinking with regard to both symptomatology and aetiology since in the former type of reaction it is the nature of the loss and the peculiar significance which this may have for the individual which are likely to be important, whereas in the latter type other factors will probably be found and the loss may be no more than a precipitating factor.

Whilst the clinical picture of typical grief is fairly clear there is little agreement concerning the types of variant which may occur; different studies have emphasized different entities and

* Nevertheless, I shall attempt, in a future article, to show that even the typical grief response contains features which are not specific to object loss.

it is only when we compare the methods of selection of cases for these studies that the reasons for these discrepancies become apparent. The main difference is between studies which emphasize inhibition or absence of grief and studies, such as the present, in which intensification, prolongation and exaggeration of the whole picture of grief is the rule. It is not surprising, therefore, that those investigations in which the method of selecting cases most closely resembles that of the present study contain the largest proportion of cases of exaggerated grief.

In our classification these two main variants of grief will be called the inhibited type and the chronic type respectively. There remains one more type in which an inhibited reaction is followed by a typical or a chronic one, this is the delayed type.

The non-specific or mixed reactions fall into no easy subdivisions and probably cover the whole range of stress disorders. Of particular note are psychosomatic illnesses, certain psychoneurotic syndromes and affective disorders not resembling grief.

This classification of bereavement reactions can be summarized:

I. The stress-specific reactions—grief and its variants:

(1) Typical grief.
(2) Chronic grief.
(3) Inhibited grief.
(4) Delayed grief.

II. Non-specific and mixed reactions. Any of the above along with:

(1) Psychosomatic reactions.
(2) Psychoneurotic reactions.
(3) Affective disorders not resembling grief.
(4) Other conditions.

I. THE STRESS-SPECIFIC GRIEF RESPONSE AND ITS VARIANTS

(1) *Typical grief*

This may occur following a major loss at any age except among the very young and the old when the overt manifestations of grief seem to be less apparent (see below).

Typical grief is characterized by the onset, after a brief period of numbness, of attacks of yearning and anxiety alternating with longer periods of depression and despair. The sufferer is preoccupied with thoughts of the dead person who is commonly felt to be present. These features, along with the associated symptoms of insomnia, anorexia, irritability and social withdrawal, soon begin to decline in intensity, although they may return from time to time at anniversaries or other reminders of the loss.

Since these features, and the studies from which they are derived, have already been discussed in Part 1, no further reference need be made to them here.

(2) *Chronic grief*

This was the commonest form of grief in the present study, being found in twelve out of twenty-one patients interviewed. It has been reported in the literature most frequently in young and middle-aged adults, particularly women, and in adolescents. In it all the usual features of grief are present as described above and some or all of them tend to be particularly pronounced. The reaction is always prolonged and the general impression is one of deep and pressing sorrow. There may be some attempt on the part of the sufferer to inhibit the full expression of his feelings by avoiding reminders or attempting to deny the loss but these are only transiently successful and it is characteristic of these patients that they are repeatedly overwhelmed by their yearning and despair.

The first to describe this kind of syndrome was Anderson (1949) who studied 100 bereaved adults who attended the Neurosis Centre at Sutton Hospital during 1944–47. Unfortunately no further details are given of his criteria for including patients in this study so that the figures which he gives are of doubtful value. He coined the term 'Chronic Grief' which he describes as, 'a chronic illness, so marked as to resemble an acute one'. This he found in fifty-nine of his cases and it is clearly the condition which we have described.

Another investigation which confirms these findings was carried out by Wretmark (1959). He studied twenty-eight adult patients (twenty-six of them women) who sought psychiatric advice at the Central Hospital, Linkoping, in Sweden, because of 'symptoms that had developed in an immediate time relationship to the loss (by death) of a relative'. Depression played a large part in these illnesses (eight had suicidal tendencies) and most of them showed in intense form the symptoms of typical grief.

Lindemann (1944), in his classical study of 101 bereaved persons, found 'agitated depression' with tension, agitation, insomnia and guilt, sometimes leading to suicide, in 'only a small fraction' of his series. It seems likely that this is the chronic grief which other workers have found so frequently and it is not clear why it was uncommon in Lindemann's series. Most of his patients, however, seem to have been seen within a few weeks of bereavement and his paper is concerned with 'the symptomatology and management of *acute* grief', rather than with the long-term effects of the loss. It is possible, therefore, that the bereaved patients who attended his 'grief clinic' represent a different population from the bereaved patients attending other types of psychiatric clinic.

Comparable results have been obtained in two other studies, both of which relate to bereavement in late childhood and adolescence. Keeler (1954) examined eleven children over the age of 6 admitted to the Bellevue Hospital with psychiatric illnesses which had come on following the death of a parent. Five of them still had symptoms of typical grief which had been present since the time of the bereavement. Clarke (1961) found that the death of a parent or sibling was a precipitating factor in the delinquency of thirty-eight out of 500 boys admitted to a Remand Home. Describing the behaviour of these boys he says: 'Instead of the normal self-limiting grief reaction, there was a prolonged working over of the bereavement experience. . . . After many months the deceased was still the focus of the perceptual field to the detriment of its other contents.' Similar preoccupation with the memory of the dead person was the rule among our patients.

As in the present study *accessory symptoms* occurred in some of the cases reported. *Guilt* appears to have been a common symptom in both Lindemann's and Anderson's studies and is reported by Wretmark in eighteen of his twenty-eight cases. In the present study it was a feature of seven of the twelve patients interviewed who showed chronic reactions. Four of Wretmark's cases also showed the *phenomena of identification* (symptoms resembling those suffered by the dead person during his last illness) which have been described in five patients in the present study.

As has been pointed out the adolescents studied by Clarke had all been placed in a Remand Home for delinquent behaviour following a bereavement and *aggressive or delinquent behaviour* was also the commonest cause of the admission of Keeler's cases. It seems to be characteristic of this age group for the resentment and anger, which are common enough components of the chronic grief of adults, to be expressed in delinquent acts.

One case from the present series will be described to illustrate the clinical picture of chronic grief:

Case G. A retired tram instructor aged 67 suffered from severe grief after the unexpected death of his wife during an attack of asthma: 'For a few days I didn't know what to do.' He made all the funeral arrangements but as soon as it was over shut himself up at home and refused to see anybody. He blamed his children, remembering little ways in which they had hurt their mother in the past, blamed the hospital for allowing his wife to die and blamed himself for sending her there. He was filled with remorse for not being a better husband although other informants said that he had coaxed and coddled his wife throughout their married life. She had been irritable with him and with the children and had been subject to a variety of neurotic symptoms but he idealized her memory and said: 'No man could have wished for a better wife.' Preoccupied with her memory he often felt as if she was in the house. From time to time he

thought he heard her and would speak to her although he knew she was not really there. He slept badly, ate little and lost nearly two stone in weight.

This situation became, if anything, slightly worse during the seven months following the bereavement. His son persuaded him to accompany him on a trip abroad but he became tense and agitated and came home early in a very depressed state. He was irritable and forgetful, caring fastidiously for his home and crying profusely whenever reminded of his loss. He lost interest in external pursuits and when he attended meetings of the local council would lose his temper and upset his fellow councillors. He felt that he no longer had any purpose in life.

Ten months after his bereavement he was admitted to hospital. After discussing his bereavement at length with the psychiatrist and being encouraged to take part in the ward activities he made a gradual improvement, regained his interest in things around him and no longer regarded the future as hopeless.

(3) *Inhibited grief*

In this type a large part of the total picture of grief is said to be permanently absent and the patient may show little reaction to the death. Most investigators seem to agree with Deutsch (1937), however, that 'every unresolved grief is given expression in some form', and various *formes fruste* of the typical reaction occur at some time or other following the loss.

No examples of this type of reaction have been found in the present study, due probably to the age and method of selection of the cases.

Inhibited reactions have been most commonly reported in children under the age of 5 but there are also two studies of adults, one of which deals exclusively with geriatric patients, in which the emphasis is on inhibition of grief.

Unfortunately there have been no systematic studies of the *effects of loss by death during the first 5 years of life;* there have, however, been many studies of other types of separation, These have been reviewed by Bowlby (1951 1960, 1961) who holds that, whilst the mourning of young children follows the same general sequence as that of adults, it 'habitually takes a course which in older children and adults is regarded as pathological'. In young children the manifestation of grief is relatively brief and overt pining for the lost parent seldom lasts for more than a few weeks. So far from being a healthy sign, however, Bowlby believes that this apparent recovery often masks 'strong residual yearning for and anger with the lost object, both of which persist, ready for expression, at an unconscious level'. These are manifested in the form of *excessive clinging and possessiveness, irritability, jealousy* and *temper tantrums.* In some cases the child may become *incapable of deep attachments* and violent or *antisocial behaviour* may continue to give trouble for years. Recent studies (reviewed by Bowlby, 1961) suggest that *some forms of depressive illness in later life* may be attributable to losses in early childhood and a variety of neuroses and personality disorders have been referred to this cause.

A classical paper connecting absence of grief with later mental illness is that by Deutsch (1937), who described four adult patients in her psychoanalytic practice who were said to have shown no affective reaction at the time of the loss (in three cases by death) of a parent. In these cases the losses had occurred during childhood and the four children had reacted in very different ways. One had shown no reaction at the time but *recurrent depression* had started at puberty; a second had never shown much affective reaction but had repeated her mother's last illness year after year in the form of *identification symptoms.* The third had repressed the memory of the mother who had died when she was 5 and had expressed no sorrow but had, at the same time, become dull, apathetic and *affectless:* 'The condition for the permanent suppression of one group of affects was the death of the entire emotional life.' The fourth patient, unable to express her own grief at the divorce of her parents, had a neurotic need to seek out situations in which she could *vicariously share the grief of others.* She had become over-controlled and capable of affectionate

love relationships only when they could not be realized.

Whilst the first of these cases could be regarded as an example of the delayed reactions to be described, in the remaining three the grief was never expressed to the full and the patient succeeded, at great cost, in permanently postponing its expression. Clearly the patients described by Deutsch would not have been included in the present study either because of their youth or because of the lapse of time between the death and the onset of the symptoms.

Brief reference to the bereavement reactions of young children in a normal population has been made by Marris (1958) and Glover (1941). Both describe a variety of responses, several children showing little or no emotion at the time of the death of a parent. Unfortunately their cases were not followed up so that it is not possible to find out if the lack of response was permanent.

Similarly, *geriatric patients* were unlikely to be included in the present study since few patients over the age of 65 are admitted to the joint hospitals. Whilst there is evidence that depressive illnesses in old age may be caused by bereavement (Kay, Roth & Hopkins, 1955), systematic studies of bereaved geriatric patients suggest that there is not normally much overt affective disturbance following bereavement in this age group.

Stern, Williams & Prados who made a special study of the problems of old people (1951) were struck by the absence of apparent grief in twenty-five bereaved patients (only one of them a man) between the ages of 53 and 70 years who attended the Old Age Counselling Service at McGill University during 1948–51. The memory of the dead person was idealized, sometimes in a bizarre fashion, and irrational hostility was often observed; but expressions of guilt or self-blame were rare. Most of the patients were suffering from a somatic illness the type varying from case to case.

Some confirmation of Stern's findings comes from a study by the writer (Parkes, 1964*b*) of the case records of unselected widows registered with general medical practitioners in the London area. This showed that widows under the age of 65 consulted their G.P.'s for help because of psychiatric symptoms twice as frequently during the first 18 months after bereavement as they had done during the preceding 2 years; over the age of 65, however, there was no such increase ($P = 0{\cdot}02$). Similarly, the amount of sedation prescribed increased by 500% in the under-65 age groups whereas there was no change in the sedation prescribed for the over-65 age group ($P = 0{\cdot}03$).

Stern has suggested that the affective disturbance of grief is somehow 'channelled' into the form of somatic symptoms, in other words, that these symptoms are affective equivalents. Cumming & Henry (1961), on the other hand, having interviewed 279 Kansas adults aged 50–70, believe that a process of 'disengagement' takes place at about the age of 65 and that 'With age occurs a mutual severing of ties between a person and others in his society', so that events such as loss of a husband are less traumatic than in younger age groups. In my own above-mentioned study there was a slightly greater increase in the consultation rate for physical illness in the over-65 age group than among younger patients so that some support is given to Stern's hypothesis—but the difference did not reach statistical significance ($P = 0{\cdot}15$).

From the foregoing it may be concluded that inhibition of grief is a characteristic of the very young and possibly of the old. It is difficult to say what the long-term effects of this may be in old age; no follow-up study has been attempted and in any case the expectation of life is such that a long follow-up would not be possible. Nevertheless, one would like to know more about the duration of these reactions and about the adaptation which is eventually made.

The only study of young and middle-aged adults in which the full manifestation of grief may have been permanently inhibited is one carried out by Stern & Larivière (1957). These authors described thirty-eight patients

admitted to the Institute Albert-Prévost in Montreal after a bereavement. Their most surprising finding was an overt lack of depression or anxiety amongst their patients, the majority of whom were said to be suffering from 'dépressions vitales', with symptoms such as fatigue, insomnia, anorexia and loss of weight. Others had phobic or obsessive-compulsive states without free-flowing anxiety and a few were diagnosed as conversion-hysteria, personality disorders and psychoses. The authors do not discuss their criteria for the inclusion of cases in the series, and, since some were clearly suffering from pre-existing conditions which were aggravated by the beareavement and others were included after a a link between the bereavement and the illness had been 'uncovered' in the course of psychotherapy, they seem to represent a different type of patient from those included in the present study. Nevertheless it is surprising that there were no patients in the present series who showed the 'dépressions vitales' described by these authors.

It may be that in this study, and in the other studies described here, we are not justified in speaking of 'permanent' inhibition of grief. Perhaps with the passing of time all Stern's cases would have expressed their grief in full and the same may be true of the reactions of childhood. Without a long follow-up the distinction between 'Inhibited' and 'Delayed' grief is hard to make and small numbers of cases have been found by Anderson and Lindemann which could be placed in either category. Probably there is no absolute difference between the two types, which simply represent different degrees of 'successful' defence.

An indirect consequence of inhibiting grief has been postulated by Paul & Grunebaum (1965). They carried out a series of studies of the families of patients with schizophrenia and state: 'Each family studied was unable to cope with loss. . . . A parent's denial of loss with incomplete mourning sensitized the bereft family members to increased dread of abandonment in relation to each other. It appears that one or both parents unwittingly selected the patient to replace the lost object, thus coping with their need to fill the void created by the loss.' This type of substitution of another for the lost person is probably not uncommon (Eliot, 1943) and since its consequences for the substitute object may be serious, require further investigation.

(4) *Delayed grief*

This takes place when a typical or a chronic reaction occurs after a period of delay during which the full expression of grief is inhibited. Sometimes the delay is simply an extension of the period of numbness which is commonly a feature of typical grief but more often even this is absent.

As described in Part 1 there were eight patients in the present study whose grief was delayed for more than 2 weeks after their bereavement.

Cases of delayed grief are mentioned in the studies of Lindemann (1944), Anderson (1949) and Wretmark (1959). Lindemann clearly regards them as the principal form of pathological variant of grief. He describes cases in which the reaction was postponed for many years and only experienced when some later loss called to mind the earlier one. Such patients 'may, upon exploration, be found preoccupied with grief about a person who died many years ago'.

Lindemann also described a variety of distorted reactions which are said to occupy the period of delay. These are often not serious or conspicuous enough in themselves to cause the patient to seek psychiatric attention. They include such features as aimless hyperactivity, identification symptoms, social isolation, furious hostility towards a specific person associated with the death and self-punitive behaviour. All of these features, with the exception of the first, have been found in some form in the present series but never replacing the grief or occurring before it. Thus five patients in the interview series showed symptoms resembling those suffered by the lost person during his last illness (*identification*

symptoms), but in none of these cases had the reaction been delayed for more than two weeks (see Table 3 in Part 1), and in no case had the identification symptoms come on during the brief periods of delay which had occurred. (Krupp has described the grief of five cases of bereaved patients with identification symptoms in a private communication. In two of these the symptoms had come on during a period of delay and in three there had been no delay.) Similarly, one patient who had lost his wife and two children in a bombing incident and had himself received a severe head injury became persistently depressed, *socially isolated and feckless*. But these symptoms came on after severe grief and did not seem to replace it (there was evidence of residual brain damage in this case). *Hostility towards others associated with the death* was common enough in our series but there was no evidence that those who expressed such ideas were inhibited or any less depressed and guilt-ridden than the ones who exhibited no such hostility; in fact, as already stated, all of the patients interviewed who expressed hostile ideas also admitted to feelings of guilt and self-blame.

Anderson mentions *inability to cry* as indicating severe guilt and all of the eight patients in the present series who had this symptom expressed ideas of self-blame. On the other hand, their guilt was not strikingly more severe than that of most other patients and it did appear that inability to cry was also related to 'numbness' and to 'difficulty in accepting the fact of loss'. Thus several patients were unable to cry during the period of numbness but were subsequently able to do so.

It is not possible to tell how frequently these delayed reactions were found in either Lindemann's or Anderson's series since neither author gives any figures. Wretmark, however, indicates that in twelve of his twenty-eight cases the reaction had been delayed for two weeks or more. This is little different from the eight out of twenty-one patients in the present study who showed a similar delay.

To sum up, there is no reason to regard any of the accessory symptoms described by Lindemann as peculiar to delayed reactions. Guilt, difficulty in accepting the fact of loss, social isolation and outbursts of elation or hostility seem to be associated, in varying degree, with several types of grief and, in the present study, identification symptoms were not associated with delayed reactions at all.

In discussing the management of bereaved patients Lindemann's main concern is to encourage the full expression of the repressed grief and one gains the impression that in his view, once the defences against grief had been removed the affective disturbance will follow its usual course towards resolution. That this is not necessarily the case, however, is borne out by the present study in which all the eight patients whose grief was delayed subsequently developed chronic reactions. There is, of course, evidence of defensive processes playing a part in the illness of all bereaved patients but the impression given by the present study is of fruitless attempts to restrain the intensity of an overwhelming affect rather than of the maladaptive suppression of a healthy affect. In the circumstances it is not surprising that Lindemann did not find the small number of cases of 'Agitated depression' in his series amenable to psychotherapy.

II. Non-specific and mixed reactions

These comprise a mixed bag of conditions which can probably be precipitated by a number of stressors and situations of which bereavement is but one. The justification for including them here is that in the examples to be discussed there is reason to regard the bereavement as a necessary though not an essential cause of the illness which followed it. The evidence for this view is derived partly from the literature and partly from the present study but in no case is it conclusive. Much more work needs to be done to establish the full range of reaction to bereavement and to find out what other factors determine a particular response.

The symptoms to be described usually start

at the same time as those of the stress-specific grief, which may itself take any of the forms described above. No special relationship was found between any particular type of non-specific reaction and any particular type of grief but in view of the small number of cases in each category this may not mean that no such relationship exists.

Just as there is a tendency for grief to recur at the time of anniversaries and other reminders of the death, it has been claimed that non-specific neurotic and psychosomatic symptoms may also occur at these times (Brewster, 1952; Stern & Larivière, 1957). Since the origin of these symptoms may only be disclosed by careful and exhaustive psychological examination, however, it is not possible to say how frequently this concurrence takes place.

(1) *Psychosomatic reactions*

Evidence for an association between bereavement and somatic illness comes from life tables which show an increased mortality for many types of illness among widows and widowers (Kraus & Lilienfeld, 1959). In a recent study Young, Benjamin & Wallis (1963) showed that this increased mortality is greatest during the first 6 months after bereavement. They regard a 'desolation effect' (i.e. grief) as probably an important cause of the increase. My own study of the case records of forty-four unselected London widows reveals a significant increase in the consultation rate with the general practitioner during the same six month period, and this increase remains when consultations for sedatives, tonics and psychiatric symptoms are excluded (Parkes, 1964*b*).

The number of physical symptoms and syndromes which have been attibuted to bereavement is very large. Thus Schmale (1958) claimed that every one of forty-two patients selected at random from the medical wards of a general hospital had suffered some object loss prior to the onset of his illness. In fact, however, only five of Schmale's patients had suffered an actual loss and the remaining losses were interpreted by him as 'threatened', 'symbolic' or 'unconscious', being communicated by slips of the tongue, and so on. It is clearly necessary for more refined methods of assessing 'symbolic' or 'unconscious' loss to be developed before the significance of Schmale's claims can be ascertained.

Marris's widows reported a wide variety of physical symptoms which they claimed had come on since their bereavement. All were common symptoms, however, and it seems likely that over a period of 2–3 years most of them would be found in any series of seventy-two middle-aged women. Most of the bereaved geriatric patients described by Stern *et al.* (1951) were suffering from somatic illnesses and the onset of these was often clearly related to the time of the bereavement. They include such conditions as arthritis, bronchiectasis, 'diarrhoea' and 'precordial pain', but controlled studies are needed to establish a causal relationship.

Other conditions for which bereavement has been held responsible include ulcerative colitis, asthma, rheumatoid arthritis and the reticuloses. Thus an interest in bereavement was aroused in Lindemann by his discovery that in twenty-six out of forty-five patients with ulcerative colitis a close time relationship seemed to exist between the loss of an important person and the onset of the illness (Lindemann, 1945, 1950). McDermott & Cobb (1939) found that six out of fifty cases of asthma first came on following the death or severe illness of a loved person. Lindemann (1944) adds rheumatoid arthritis to the list but without figures to support the claim. Finally, Greene *et al.* in a series of papers (1954, 1956, 1958) concluded that loss or threat of loss of a love object is a cause of reticuloendothelial disease. They found evidence of such losses in seventy-eight out of eighty-five patients at the time of onset of a leukaemia. Whilst the figures given in these and the other studies which have been described do suggest that these conditions may be caused by bereavement, in the absence of controls no definite conclusion can be drawn.

One investigation which does make use of a control group gives equivocal results. This was carried out by Imboden, Canter & Claff (1963) who studied 500 normal adult employees at Fort Detrick, Maryland. They found that 25·7 % (117 employees) reported some illness, separation or divorce at the time of interview or a death within the last year in a parent or close relative. Comparing the 'Separation' Group with 100 controls selected at random from the remainder they found no significant difference in the number of clinic visits among the separated (2·1 visits/patient) and non-separated (1·9 visits/patient) patients. There was, however, a significant increase in the Cornell Medical Index ($P < 0{\cdot}001$) in the 'Separation' group. But within this group C.M.I. scores were higher after losses of distant relatives than losses of close ones and higher among patients who had lost a relative more than seven months ago than among those who had lost a relative during the last seven months. Both of these findings go against the hypothesis that separation was a cause of the raised C.M.I. score and the writers suggest that they may reflect the 'reporting characteristics' of the subjects.

The weakness of this otherwise excellent study lies in the selection of cases for inclusion in the 'Separation' group. Thus in sixty-two out of 117 the 'separation' was no more than an illness in the family, only seventeen had lost a parent by death during the preceding year and none had lost a spouse.

Since patients are seldom referred to the Bethlem Royal and Maudsley Hospitals for treatment of psychosomatic conditions it is not surprising that few cases were found in the present study. In fact only one of the conditions usually regarded as psychosomatic occurred among the patients interviewed by the writer. This was an attack of urticaria which came on the at the same time that a man, who had had a delayed reaction to the death of his wife, began to express his grief.

There were several patients in the case-note series who developed psychosomatic conditions. These included two who had attacks of rheumatoid arthritis, one with asthma and several with 'nervous rashes'. In all these cases, however, there were stressors apart from the bereavement which might have contributed to the onset of the symptom.

(2) *Psychoneurotic reactions*

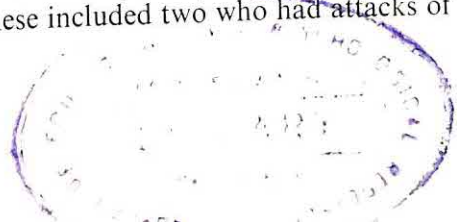
Quite apart from 'identification symptoms', which are a special kind of hypochondriacal symptom specific to grief, the preoccupation with thoughts of death and disease which commonly occurs in the bereaved seems to predispose susceptible persons to develop hypochondriacal symptoms, phobias of death or major illnesses, obsessional preoccupations and/or depersonalization.

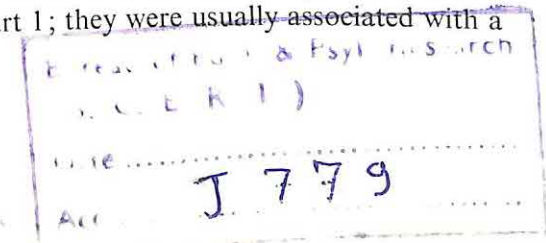
Stern & Larivière (1957) found that fears of death, fears of poison or avoidance of dirt were common symptoms in their series of thirty-eight psychiatric patients, and Anderson (1949) claims that 7 % of his cases were suffering from 'obsessional tension states'.

It seems likely that many of the 135 patients, described by Roth (1959), who developed a phobic aversion to leaving familiar surroundings and depersonalization following a variety of psychological traumata, could be included in this category. In fact 37 % of the illnesses of his patients are said to have followed closely on a bereavement or a sudden and serious illness in a close friend or relative.

In the present study hypochondriacal symptoms were common and seemed usually to stem from the autonomic disturbances which accompany grief. Thus patient Q complained of 'nervous bubbly feelings in her stomach' and 'trembling in her legs' which were aggravated by reminders of her dead brother; patient F complained of breathlessness and choking sensations which were worse at the time when her dead husband would normally have returned home from work; and patient O complained of a dry throat and palpitations at night associated with feelings of loneliness.

The phobic panic attacks which occurred in six interview cases have already been described in part 1; they were usually associated with a





personal fear of death and were brought on by reminders of loss, death or violence. But they did not differ from the panic attacks which commonly occur in phobic patients whatever the aetiology of the phobia.

Frank obsessional symptoms were the main symptom in only one case. In this patient erotic and aggressive ruminations began obtruding into her thoughts 4 weeks after the death of her mother. She subsequently developed a chronic obsessional neurosis with compulsive rituals which occupied her waking hours and were not relieved by leucotomy.

Three patients were depersonalized at some time during the course of their illness, but this symptom was not a prominent one and seemed to consist of no more than an exaggerated form of the 'numbness' which has been described. Unlike the patients described by Roth, there was no evidence of phobic anxiety until after the depersonalization had passed off and the patient was able to experience grief.

There is much to be learned from a close study of cases such as these about the nature of bereavement and the psychoneurotic symptoms which follow it; but the issues are complex and the evidence available does not yet justify further generalization.

(3) *Affective disorders not resembling grief*

Into this category fall certain cases of anergic depression and mania which bear no resemblance to grief although they may replace it.

Without wishing to take part in the long-standing controversy concerning the classification of the depressions, it is worth noting that the so-called 'endogenous' (anergic or retarded) form of depression has rarely been described following bereavement. Thus Anderson diagnosed 'anergic depression' in only 4% of his cases and other authors make no mention of the condition.

In the present study there were no cases of retarded or psychotic depression in the interview series but three cases were found in the case note series.

Rather more surprising a sequel of bereavement is mania. This is a rare occurrence and no large series has yet been published; a few cases, however, have been described by MacCurdy (1925), Lagache (1938), Bonnafous-Sérieux & Ey (1938) and Abely & Leconte (1938). Between them these studies include thirteen patients all of whom developed symptoms of typical mania within 7 days of a major bereavement. In at least five cases there were times when the patient had delusions of the persisting life of the deceased person and several of them carried on conversations with him.

One patient in the present study who had a typical manic illness will be described.

She was a spinster of 38 who lived at home with her parents. A pampered, overprotected girl she was very attached to her married sister, Bessy, who lived nearby. When Bessy became ill the family did not tell the patient she had cancer because they feared 'the shock would be too much for her'. After the death she cried for a while but afterwards 'I did not give her another thought'. Her father, however, became depressed and 'started talking nonsense'. He eventually had to be admitted to an observation ward and at about the same time another sister was admitted to a general hospital with a recurrence of the ulcerative colitis from which she had suffered for some time. Four days later our patient became excited, overactive and elated. She started trying on the clothes of her dead sister and carrying on conversations with her. She was admitted to hospital and showed typical manic thought disorder with flight of ideas, distractibility and great pressure of talk. At times she spoke of her dead sister and said, 'Bessy's dead, but no, God hasn't taken her, she's here'. At other times she became ecstatic and made obscene advances to hallucinations of Bessy's husband. Subsequently the condition gradually improved and she settled into a state of chronic hypomania.

In this case the sister's death was only one among several stresses which probably contributed to produce the manic illness. Since, however, the illnesses and admissions to hospital of father and remaining sister can be regarded as other forms of loss it seems

reasonable to regard this case as a bereavement reaction.

No cases of frank mania have been reported by Lindemann, Anderson or Wretmark in their studies of bereaved psychiatric patients, but Anderson does mention '*bursts of elation and triumph* interspersed in a background of depression' and two examples of this were found in the main series. One, a woman, had uncontrolled attacks of laughter after a cat walked out of the room which contained her mother's body. She had been told that a cat will eat the face of a corpse. This case is not quite typical because the patient denied feeling elated even when laughing.

The other, also a woman, had three brief episodes of hypomanic elation in the course of chronic grieving for the loss of her husband. Two episodes occurred whilst she was taking drugs (Chlorpromazine and Iproniazid) and the third when she was told by some friends that her husband was 'always with her'. Following each of these episodes she soon returned to her usual depressed state.

(4) *Other conditions*

Schizophrenia-like pictures have been described by Lindemann (1944) and by Stern & Larivière (1957), but several of the examples they give could be regarded as cases of affective disorder and in others the relationship to the bereavement is by no means clear. No examples were found in the main series of the present study and although there were eight cases in the subsidiary series in whom typical schizophrenic symptoms came on within 6 months of a bereavement, it is possible that this might be a chance occurrence. As was shown in a previous paper (Parkes, 1964*a*) 15 % (481 out of 3111) of non-bereaved admissions to the joint hospitals during 1949–51 were diagnosed 'Schizophrenia' compared with only 8 % (eight out of ninety-four) of bereaved admissions.

Although Anderson (1949) states that '*homosexual dreams and behaviour*' may occur, he does not include such cases in his diagnostic classification or cite any case material. No examples of sexual deviation were found among the patients in the present study.

Relapse in chronic *alcoholics* is commonly related to environmental stress and it would be surprising if bereavement was not an occasional cause of this. In fact there were thirteen patients in the whole series who had alcoholic episodes and five of these subsequently developed Korsakov's Syndrome.

Conclusions

This account of the various reactions to bereavement is not complete. No doubt further research will add to their number and clarify the relationship between those which have been described. One of the first requirements is a study which will establish clearly the sequence and duration of the features of typical grief.

Whilst the occurrence of depression as a prominent symptom at some stage or other of most forms of grief has justified placing grief among the reactive depressions, grief does not fit readily into any of the orthodox diagnostic categories. As Anderson (1949) has pointed out, patients suffering from grief and its variants show very different clinical pictures at different times in the course of the reaction. Thus, if seen during the period of numbness or delay they may show a general flattening of affect; during a period of yearning they may be agitated, restless and anxious; whilst at other times they are depressed, apathetic and withdrawn. The presence of identification symptoms may lead to a diagnosis of hypochondriasis or hysteria and mixed pictures further complicate the issue.

If, however, we accept grief and its variants as a diagnostic group, distinguished by aetiology, psychopathology and symptomatology from other illnesses, the diagnosis is seldom difficult to make. The patient is usually preoccupied with and well aware of the nature of his feelings and even during the period of delay there is a tendency for symptoms of grief to break through. In these cases the full

picture is conspicuous by its absence, the patient and his relatives are surprised by the apparent lack of affect and are waiting for the 'break down' to occur.

If grief has been long delayed, however, its nature, when it finally appears, may not be obvious. The patient may have much difficulty in expressing his feelings or he may displace them on to an inappropriate object so that their real cause is only discovered in the course of psychotherapy. It is not yet certain how often apparently 'unmotivated' attacks of depression can be ascribed to delayed grief; nevertheless, there are some who hold that all forms of depression originate from grief and their theory is worthy of the fullest investigation.

Another diagnostic problem may arise during the acute stage of grief when it is necessary to predict whether or not the condition is likely to become chronic. Two types of factor seem to be important; present symptoms and past history. From this study it seems likely that a particularly intense reaction with much self-blame and a great deal of difficulty in accepting the fact of loss will be followed by a prolonged reaction, but the predictive value of each of these factors separately has not yet been established. Factors antecedent to the bereavement which are associated with a poor outcome will be discussed in a later paper. Most of them are easily assessed and relatives often expect the patient to 'take it badly'. This sometimes engenders a conspiracy of silence regarding the severity of the terminal illness so that when death occurs the survivor is quite unprepared for it.

The non-specific bereavement reactions are less straightforward. Theories exist which attempt to show a direct connexion between repressed sorrow and asthma, between mourning and mania, and between separation and diarrhoea, but the scientific evaluation of these theories is hard and the issues are likely to remain controversial. Even if future research confirms the indications of this and other studies that there is a significant increase in these conditions following bereavement we are still a long way from explaining the increase in causal terms. We do not know, for instance, how psychological stress comes to exert its undoubted influence on such conditions as ulcerative colitis and bronchial asthma and the intermediate variables involved in the 'manic defence' are the subject of much speculation.

Nevertheless, there are some who will object to the delineation of a separate category of *non-specific* bereavement reactions, or to the allocation of certain syndromes to this category on the grounds that the conditions described do in fact have a specific relationship to 'object loss' rather than a general relationship to 'stress'. The onus however would seem to be upon them to demonstrate how it is that these conditions commonly occur after a variety of stresses which do not appear to be types of object loss. True a 'stress' can only be defined in terms of its effects but so long as no specific relationship can be demonstrated between particular 'stressors' and their effects the term would seem to be a useful one.

Although this study has been concerned only with the effects of loss by death of a first-order relative there are many other forms of object loss and it remains to be seen how closely the reactions to these resemble the bereavement reactions which have been described. What evidence there is suggests that there are many points of similarity between the grief of the bereft and the reaction to loss of a home (Fried, 1962) or a limb (Fisher, 1960). Dying men are said to experience grief for the anticipated loss of all their love objects (Aldrich, 1963) and there is a growing emphasis among psychotherapists on the importance of helping the patient to express grief for the various losses which he has experienced during childhood and later life including the loss of his therapist at the end of treatment (see, for instance, Wetmore, 1963).

All of which leads us to suspect that, far from being an event of only marginal interest to the psychiatrist, grief may prove to be as

important to psychopathology as inflammation is to pathology.

Summary

In this article the clinical picture of the 115 bereaved psychiatric patients, whose grief was described in Part 1, is compared with the reaction to bereavement of psychiatric patients described in other studies.

A classification of bereavement reactions is derived:

I. Grief and its variants.

(1) Typical grief. A complex but relatively stereotyped reaction having a characteristic and readily identifiable form and course.

(2) Chronic grief. An abnormal prolongation and intensification of the typical form, frequently associated with ideas of guilt and self blame, identification symptoms and-or aggressive or delinquent behaviour.

(3) Inhibited grief. A large part of the total picture is lastingly inhibited but certain other symptoms, some of which resemble aspects of grief, occur in its place. This type seems to be most common in the very young and the old.

(4) Delayed grief. This is a mixed form in which a typical or chronic reaction takes place after a period of delay which may range from weeks to years in duration. As with inhibited grief distorted forms may occur during the period of delay but there is no reason to regard them as peculiar to this form of grief.

II. Non-specific and mixed reactions.

These include a number of disorders which can probably be precipitated by a variety of stressors. They include:

(1) Psychosomatic conditions, particularly ulcerative colitis.

(2) Psychoneurotic reactions, in which hypochondriacal, phobic or depersonalization symptoms predominate.

(3) Affective disorders not resembling grief, the most important being mania.

(4) Other conditions include alcoholic episodes.

It is hoped that this schema will provide a framework into which other types of bereavement reactions can conveniently be fitted.

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Some metapsychological aspects of interpretation*

By CLIFFORD YORKE†

I. Introduction

Interpretation as a technical device has such a central place in psychoanalysis that it is surprising that the literature contains relatively few formal accounts of its metapsychological status. Notable exceptions include Nunberg (1932) and Fenichel (1935, 1941). It is true that Rapaport (1953) has suggested that psychoanalysis is far from being able to formulate a metapsychology of treatment and technique. Nevertheless, it may be profitable to assemble the bare bones of our present-day theoretical understanding of interpretation, to indicate the lines on which this knowledge may be extended by the insights of modern ego-psychology, and finally to try to suggest ways in which many of the contributions to this subject, scattered throughout an extensive literature, can be integrated. Furthermore, there seem to be cogent reasons, arising from the changed historical circumstances in which psychoanalysts practise, why such a study should no longer be delayed; and I shall begin by briefly discussing them.

When psychoanalysis was still a very young science, and met with little understanding and much abuse, its practitioners necessarily worked in professional isolation. Indeed, on the occasion of what Freud (1910) called the first official recognition of psychoanalysis, in the first of his lectures delivered at Clark University, he not only emphasized the disparities between medical and psychoanalytic disciplines but stated categorically that it was not without satisfaction that he had learned that the majority of his audience were not members of the medical profession. Equally, relations with academic psychology were no better.

Today this is no longer the case. The abuse is muted and the threats to psychoanalysis less overt. Not only do many analysts work in close association with other medical colleagues and, particularly in the United States, hold influential academic and teaching posts in general psychiatry, but the growth of ego-psychology and the influence of analysed psychologists has done much to heal the breach with academic psychology. Even in Britain, where conditions are not yet so favourable, the process has been accelerated by the introduction of the National Health Service and seems likely to continue.

An important consequence of these changing circumstances is the increasing participation by analysts in all parts of the world in various forms of psychotherapy. The development of psychotherapy in relation to psychoanalysis has been extensively examined by Glover (1960) and it would be superfluous to consider it here. What must be emphasized is the impressive diversity of techniques employed. Moreover, this diversity is by no means a mere reflexion of obvious formal differences in treatment-settings, such as distinguish group from individual therapies, for even with a similar formal framework there are considerable differences of belief and practice.

The danger of confusing analytic techniques with other forms of treatment is unlikely to be serious where simple measures of counselling and support are concerned, whether practised by analysts or not. The same can be said of frank suggestion, especially since its theoretical basis has received close attention from psychoanalysis from its earliest days (e.g.

* Based on a paper read to the Medical Staff Meeting at the Cassel Hospital, Richmond, 6th December, 1962.

† Cassel Hospital, Richmond, Surrey.

Ferenczi, 1909; Jones, 1923; Rado, 1925; Glover, 1931). The real difficulties arise with the so-called dynamic psychotherapies. On the one hand, there are analysts who, like Alexander (1944, 1953, 1954; Alexander & French, 1946; Alexander & Ross, 1952), assert that there is no fundamental distinction between psychoanalysis and their briefer dynamic techniques; on the other, there are those who, like Glover, insist that any kind of psychological treatment other than psychoanalysis is overt or covert suggestion.

In the United States, the controversy, often centring on the Chicago (Alexander) and Washington (Harry Stack Sullivan) schools, has stimulated many valuable papers which help to clarify related issues. Among these are contributions by Berliner (1941), Bibring (1954), Eissler (1950, 1953), Gill (1954), Gitelson (1951), Rangell (1954), Reider (1952), Stone (1951, 1954) and Waelder (1945). In Britain attempts to apply psychoanalytic findings to other interpretative psychotherapies have received considerable impetus from work at such centres as the Cassel Hospital and the Tavistock Clinic, though, with the exception of Malan (1963), few conclusions have so far been published. Similarly, an increasing number of British analysts, among them Ezriel (1950), Foulkes (1946*a*,*b*, 1953) and Sutherland (1952), have contributed to the growing volume of literature on 'group-analysis' and group-analytic psychotherapy on both sides of the Atlantic. Finally, the need for an accurate assessment of results has been the subject of such recent studies as those by Malan (1959) in England and Wallerstein (1963) in the United States.

The present writer shares the somewhat widespread view that psychoanalysis as a therapy is simply one of a number of treatment techniques based on psychoanalysis as a theory of mental functioning and human adaptation. However much these techniques may otherwise differ, the 'dynamic' and 'interpretative' psychotherapies have, ostensibly, one procedure in common with psychoanalysis; namely, the use of interpretation. Interpretation as a technical device has, of course, such a fundamental place in psychoanalysis that every other technical measure—including the analytic setting itself and the transference situation—is secondary to the creation of those conditions in which effective interpretation is possible. Furthermore, this privileged position is based on firm metapsychological considerations. The danger, perhaps, for analysts who practise other forms of psychotherapy is that they may borrow a technical device, originally used only in a setting specifically designed to make it effective, and use it in a context in which, on theoretical grounds, its employment has neither justification nor validity.

This danger is not lessened by the comparative neglect of Freud's prestructural contributions to metapsychology (Freud, 1900, ch. VII, 1911, 1912*b*, 1914*a*, 1915*a*, *b*, *c*, 1917*a*, *b*), a fact which Glover (1945, 1947, 1961) has repeatedly emphasized and which Rapaport (1960) has called 'one of the most puzzling problems in the history of psychoanalysis'. Whatever the explanation, a consequence of this is that structural considerations tend to be emphasized at the expense of dynamics and economics, sometimes with the implicit assumption that the older topographical formulations have been entirely superseded. But if this circumstance is unfortunate for psychoanalysis it is no less so for those who try to bring psychoanalytic insights to bear on other forms of clinical work. The fact is that, once freed from even the form of an analytic method, the need to conceptualize techniques in metapsychological terms is unlikely to seem so imperative.

The position is not made easier by the lack of agreement on what constitutes effective interpretation even within the formal framework of the psychoanalytic method proper. This is especially true where matters of timing and depth are concerned and has been a source of controversy, particularly in England, since Melanie Klein (1932), probably independently, revived a technique first advocated by Stekel (cf. Fenichel, 1945, p. 25). This seems a

further compelling reason for making a scrutiny of interpretation as a technical device in the light of Freud's metapsychology. I want, therefore, to consider those changes which are bound to occur in the mental apparatus if interpretation is to lead to any effect other than that of suggestion.

There is one preliminary difficulty. Transference interpretation in psychoanalysis has a status and authority accorded no other kind of intervention. It is therefore of some importance to begin by considering certain relevant aspects of the theory of transference and the transference-neurosis. What follows is, for convenience, divided into three parts. The first consists of a brief survey of the theoretical concept of transference with special reference to the analytic situation. In this I shall keep largely to metapsychological considerations in order to pave the way for the section which follows. This takes the form of a discussion of those metapsychological aspects of interpretation which seem relevant for our present purposes. Finally, certain questions are raised which seem to me to confront us when we apply these theoretical principles to treatment situations which may otherwise have little in common with psychoanalysis.

II. Some theoretical aspects of the transference

In this short theoretical summary special emphasis will be laid on the differences, in the psychoanalytic setting, between spontaneous transference and the transference-neurosis. However, there are two preliminary points I wish to make. The first is that some British analysts do not make this distinction and adopt a theory of transference, based on the work of Melanie Klein, which is very different from the classical view on which this presentation is based. The second is that the account which follows is mainly concerned with transference in the psycho-neuroses and does not deal with those variations encountered, for example, in children, delinquents or psychotics.

Spontaneous transference in the analytic situation is present from the beginning. It does not differ essentially from the spontaneous transferences of everyday life, both positive and negative. It is therefore a direct reflexion, by a process of simple displacement, of the current state of the patient's object relations. It is true that these attitudes derive from the past, but their genetic roots are sometimes relatively remote. Accordingly, spontaneous transference lacks the specificity of the transference-neurosis.

Spontaneous transference is, however, encouraged by the patient's illness, his wish to seek help and his 'readiness for transference'. In this connexion Freud (1912*a*), in his paper on the dynamics of transference, pointed out that if someone's need for love was not entirely satisfied by reality he was bound to approach every new person he met with 'libidinal anticipatory ideas'. This attitude, of course, plays an important part in the development of the transference-neurosis itself.

Unlike spontaneous transference, the transference-neurosis almost always takes time to develop. Further, it is no longer a simple displacement since it demonstrates the entire process and structure of symptom-formation. The neurosis now centres on the analytic situation and henceforth can be understood in terms of the analytic relationship. Freud said that there was no neurosis without an infantile neurosis; in the transference the infantile neurosis is now laid bare.

In addition to the 'readiness for transference' the transference-neurosis is fostered by two other factors; namely, the repetition-compulsion and the regressive nature of the analytic situation. The compulsion to repeat was described by Freud in his paper on 'Recollection, Repetition and Working Through', developed in 'Beyond the Pleasure Principle' and summarized in 'An Autobiographical Study' (Freud, 1914*b*, 1920, 1925). For Freud the repetition-compulsion expressed a conservative trend in the organism, a tendency to cling to old methods of adaptation at the expense of the new. Early traumatic experiences were thought of as releasing large

quantities of instinctual energy which were subsequently bound, later to be released in relatively minute quantities when similar situations were encountered, or (if we include his later views on anxiety) anticipated. Freud also discussed the operation of this principle in children's play and in traumatic neurosis.

It is, then, the operation of the repetition-compulsion which displays in the transference this apparently infantile addiction to the past. It is, however, the factor of regression which permits its operation with such force and clarity. More than any other circumstance regression is fostered by the analytic situation itself. The factors responsible have often been enumerated (e.g. Macalpine, 1950; Nunberg, 1951; Gill, 1954; Waelder, 1956). We can mention here the relative helplessness of the patient in the face of professional authority; the recumbent position which underlines and augments this; the fact that the analyst is out of view, is relatively passive and says little; the basic rule with its relative restriction of attention to the patient's own mental processes so that reality-testing is more or less suspended; and the limitation of motility which not only frustrates the wish for gratification in action but also permits instinctual discharge only in recollection and affect. In such circumstances, instinctual regression is very greatly facilitated.

As in all symptom-formation the regression of instinct in the transference-neurosis follows a situation in which the wish for gratification is both urgent and denied. Instinctual introversion is succeeded by regression to a fixation-point (which will vary, *inter alia*, with the neurosis). Historically, this represents a point at which there is a particularly close attachment of instinct to its infantile object (Freud, 1912*a*). This close attachment is now augmented by the regressive reinforcement of instinctual cathexis, though in the transference the analyst-imago takes the place of the original object-representation. This reinforcement tends to bring about the return of the repressed in the form of one of the derivatives of the unconscious wish, although we can only fully understand this process if the situation is now examined from the standpoint of the ego.

Turning then from the id to the ego, we find in the transference-neurosis the emergence of an ego-organization which has otherwise been historically superseded. We find an archaic defence-organization appropriate to the phase to which the instinct has regressed. The ego has become an infantile ego, ill-suited to the tasks demanded of it, and to that extent it is crippled. But in the transference a new factor is added. The distributions of anticathexis manifest in the infantile defences are now reinforced from another source, namely, the transference-resistance itself. Attention-cathexis is withdrawn from the analyst-representation and now augments the infantile anticathexis; clinically this stage is recognizable as the first real resistance in the analysis with a pronounced change in the patient's behaviour. The minor pauses of spontaneous transference may, for example, give way to prolonged and uncomfortable silence, anxiety of greater severity or restlessness. An initial phobia may now become quite specifically attached to the analytic hour. The instinctual reinforcement at a fixation-point has called forth a defensive reinforcement of anticathexis, and the transference-neurosis is established by the usual method of compromise. Henceforth the patient's material can, wherever indicated, be directly related to the analyst in the work of interpretation. But we have yet to account more fully for those distortions and substitute-formations which, in the transference-neurosis are analogous to those observed in other kinds of symptom-formation.

We can clarify the situation further if we note that regression in analysis is not confined to those vicissitudes of ego and instinct together designated by Freud (1900, 1917*a*) as 'temporal regression'. All three types of regression—temporal, topographical and formal—can be observed. If we consider topographical regression (that is, regression from a higher to a lower psychic system) we can see the importance of the basic rule in making analytic work possible. For by this rule

reality-testing is held in comparative abeyance and preconscious thought processes are less exclusively subject to conscious control and the influence of the secondary process. In short, the id holds greater sway and primary process functioning is more evident. Formally, it could be said that thought approximates more closely to ideation and, indeed, in some cases—for example, so-called borderlines—this process may be carried so far that communication is too severely disrupted and analysis becomes impossible. Just as, in the symptom, we may see evidence of both primary and secondary process expression, of disturbed instinctual gratification and inappropriate defence, so too we can see this in the formation of the transference-neurosis.

The regressive phenomena subserve the immediate requirements of ego and id in a symptom-compromise, but the ego's part in the analysis is not solely one of resistance. Part of the ego becomes an analysing part which identifies with the analyst, as Sterba (1934) pointed out. Bibring (1937), amplifying this concept, again stressed the split by means of which a scrutinizing part of the ego could stand apart and follow the struggle between instinct and defence. (It is true that this process is partly contingent on the fate of the superego during treatment, but this question will be deferred for a moment.) Ego-regression, therefore, cannot be solely considered in terms of resistance but can equally be an example of 'regression in the service of the ego' or 'controlled regression' (Kris, 1936, 1956*a*).

Indeed, in spite of these regressive tendencies, it is clear that the hold on reality is rarely abandoned entirely in the transference-neurosis. If it were, analysis would not be possible. Of the greatest importance in successful analytic work is the maintenance of the adaptive function of the ego and the degree of ego-autonomy necessary to meet the reality of the analytic situation and its minimum requirements. Through the work of interpretation anticathectic energies can be withdrawn and their more highly neutralized resources put at the disposal of the autonomous ego. In this way, too, as the analysis proceeds, greater areas of the formerly crippled ego can acquire secondary autonomy (Hartmann, 1950, 1952, 1955).

These questions will receive further consideration in section III of this paper. Meanwhile, the role of the superego requires some attention. Strachey (1934) published an influential paper in which he understood transference in terms of the projection on to the analyst of the patient's superego, its modification through what he called 'mutative interpretations' and its subsequent re-introjection. While this view was based on a terminology and theory of superego formation which has not found general acceptance, we do know that the superego tends to be externalized in analysis and that its punitive and sadistic aspects are often experienced in all their archaic severity. In this respect the analyst's tolerance has both a mitigating and an educative function, a direct influence on the patient which is not brought about solely by the content of interpretation. In his recent paper on the concept of the superego Sandler (1960) has pointed out that situations exist in which the standards and precepts of the superego are totally disregarded provided that the ego is otherwise assured of adequate narcissistic supplies. He gives examples and shows how both the analyst and the psychotherapist provide such supplies through their supportive role, so permitting the emergence into consciousness of forbidden and repressed material.

This view, of course, takes into account the libidinal relationship between ego and superego, a matter which is sometimes forgotten in the customary emphasis on the primitive savagery of the latter structure. In his paper Sandler shows how objects once introjected can be restored to the external world—a process he refers to as 'superego regression'. With this we can complete our brief survey of the regressive changes in the structural triad.

We have now considered, if very incompletely, transference from the standpoints of

id, ego, superego and reality. Economically, it has been noted that a redistribution of mental energies occurs in the formation of the transference-neurosis. Dynamically, the fate of instinctual energy and its permissible discharge in the transference of recollection and affect has been referred to. It is worth considering its further possible discharge in 'acting in the transference' and 'acting-out'.

In 'acting in the transference' the strict rule of the analytic situation is temporarily transgressed and recall and affective experience are partly replaced by some form of acting. This may take the form of attempts to prolong exchanges after the session or to make social contact with the analyst. Such 'acting in the transference' is usually observed at points where the transference-neurosis is particularly intense.

In 'acting-out' the id-strivings and the defences against them are displaced from the relationship with the analyst to other relationships in everyday life. This 'acting-out' of unconscious wishes takes place instead of recollection, and an id-resistance, the repetition-compulsion, has joined forces with the transference-resistance of the ego. In this respect Anna Freud (1937) has said that the ego 'makes common cause with the id and simply carries out its behests'.

Finally, it may not be out of place to conclude this part of the discussion with the observation that the transference and the transference-neurosis are not the whole of the treatment relationship and that analysis is a shared experience in which there is also a real relationship between two people. The transference-neurosis obscures this relationship; but it does not do away with it.

III. On the metapsychology of interpretation

It is now possible to consider, again from a theoretical standpoint, those changes in the mental apparatus which we would expect to occur when 'effective' interpretation is made. For convenience, those changes which are wholly due to suggestion will be excluded.

It is not difficult to *summarize* the changes to be expected; it is their amplification which gives rise to so many problems. Structurally, it may be said that, as a rule, interpretation contributes, no matter how minutely, to the strength of the ego in its attempts to meet the triple requirements of id, superego and reality, perhaps mitigating, in the process, superego severity. It acts by naming ego-defence and id-impulse, usually in that order, and demonstrating them to the scrutinizing part of the patient's ego which is identified with the analyst. Topographically, it 'makes the unconscious conscious', in the process of which the connexions between thing- and affect-presentations on the one hand and word-presentations on the other are restored. Economically, it releases quantities of anticathectic energy which become available for other ego activities. Dynamically, it permits discharge of small quantities of instinctual energy in recollection and affect. To these classical viewpoints may be added the genetic aspects of interpretation, by which the historical basis of current derivatives is brought to consciousness, and the adaptive aspects* by which formerly conflictful functions of the ego may reach secondary autonomy. It will be convenient to begin with certain economic considerations.

In his paper on repression Freud (1915*b*) distinguished primal repression from repression proper. In primal repression the ideational representative of an instinct was denied entry into consciousness, a process effected by anticathexis. The instinct-representative did not of course disappear; the instinct became fixated and its representative persisted unaltered. Furthermore, it exercised an attraction upon everything with which it was connected, in this way complementing the effects of

* These viewpoints have only secondary status, since genesis and adaptation concern object-relations which, in turn, can be described in terms of structure, economics and dynamics.

anticathexis. Repression proper, on the other hand, affected the mental *derivatives* of the instinct-representatives in the system *Pcs*; these derivatives were themselves subject to anticathexis within that system and were therefore treated as if they too were structures in the system *Ucs*.

The source of energy for anticathexis was suggested by Freud (1915*c*) in his next metapsychological paper. He distinguished two kinds of ego-energies: those employed in anticathexis and those available for attention-cathexis (hypercathexis). In repression proper attention-cathexis was withdrawn from the *Pcs*. derivatives of the instinct-representative which were then themselves subject to anticathexis. Freud's suggestion was that the energy used in the latter process was derived from the original hypercathexis.

A necessary corollary of this theory of repression is that the amount of energy expended in the anticathexis of any particular derivative will depend on the proximity of that derivative to the initial fixation-point. To use a spatial analogy, it is inversely proportional to the psychic distance of the derivative from the instinct-representative. The more remote the derivative, the weaker will be the anticathexis required. This has obvious implications for psychoanalytic technique.

For an instinctual derivative (whether idea, affect-charge, simple thought or complex phantasy) to become conscious the anticathexis must be withdrawn and attention-cathexis restored. In psychoanalysis this is effected by interpretation. When the defence against the impulse, the derivative of the impulse, or the impulse itself is named the words used by the analyst are registered and invested with attention-cathexis. If the interpretation is successful—and, theoretically, everything depends upon timing, accuracy and topographical depth—this hypercathexis is achieved by the use of energy which, until the moment of speaking, was employed in anticathexis. Of course, interpretation does not necessarily work at the moment of utterance (see below). However, it is evident that, if a topographically 'deep' interpretation is made without adequate preparation, fresh registrations are laid down in the system *Pcs*. with one of two consequences: they are either invested with attention-cathexis from freely available ego-energy only (in which case they have no effect on the systems of anticathexis employed in defence) or they themselves become subject to anticathexis so that an increase in resistance may be clinically manifest. It is clear that neither process has anything to do with 'making the unconscious conscious'. A third possible consequence of premature interpretation—namely, the precipitate break-through of *Ucs*. material—is referred to below.

Interpretation, then, deals with the various links in the chain, removing anticathexes step by step until the instinct-representative is opposed by only the feeblest ego-energies. Here there are two circumstances which come to the aid of the analyst in his attempt to undo any remaining opposition to consciousness. The first is, quite simply, the pressure of the instinctual drive towards discharge, though it seems unlikely that this, in itself, would suffice to overcome the resistance. The second is the presence of a transference-situation whereby the accumulation of regressive instinct reinforces the id at the initial fixation point. It is, of course, precisely this pressure of instinct which, if we are lucky, gives each analytic hour a discernible theme. This fact seems particularly important in view of its implications for treatment situations where no real transference-neurosis exists.

Clearly, interpretation has the best chance of success if it is made at the right point in the chain. This is what Fenichel (1941) meant when he said that we must tell the patient what he already knows and 'just a little bit more'. If, however, a 'deep' interpretation *does* succeed in removing a greater quantity of anticathexis at any one moment, the danger is that the appropriate affect-charge released by the interpretation will be more than the patient is ready to tolerate and will overwhelm the ego in a panic attack.

It is evident from these economic con-

siderations that the process of interpretation restores the instinctual derivatives to their preconscious state. Functionally regarded, a preconscious representation is one which is without anticathexis and which is therefore capable of becoming conscious, when the ego requires it, by a simple act of hypercathexis. Regarded systematically, however, matters are not so straightforward since we know that, in certain circumstances, *Pcs.* material may be repressed into the *Ucs.* We now have to answer the question: at which topographical barrier does the act of interpretation work? Does it operate at the *Pcs./Cs.* border, or does it exert its effect at the border between the systems *Pcs.* and *Ucs.*?

Economic considerations would suggest that we work at the former until, through bringing into consciousness the intermediate links, the original instinct-representative has itself become accessible to the system *Pcs.* Nevertheless, there are difficulties in any explanation of a treatment process which implies interpretative work at two different topographical levels; and the adoption of a hierarchical model, on lines suggested by Kris (1950), Hartmann (1950, 1951) and Rapaport (1950, 1951), seems necessary for the resolution of this problem. Given a system which allows all gradations between primary and secondary process functioning with, correspondingly, every degree of neutralization and binding, we are concerned only with the one level of the system at which interpretation can be effective.

The changes in ego-cathexes which follow interpretation relate largely to word-presentations. Freud's views on the relationship between word- and thing-presentations were adumbrated in 'The Interpretation of Dreams', developed in 'The Two Principles of Mental Functioning' and made explicit in his paper 'The Unconscious' (Freud, 1900, 1911, 1915*c*). In the latter he concluded, from an examination of schizophrenic thinking, that 'the conscious presentation comprises the presentation of the thing plus the presentation of the word belonging to it, while the unconscious presentation is the presentation of the thing alone'. Repression denies to the thing-presentation its connexion with the word; the restoration of this link is the task of interpretation. A subsequent qualification by Freud (1938) does not affect the present argument though it is evident that links must also be re-established with all relevant psychic content (cf. Rapaport 1951).

Anticathectic energies freed by interpretation remain at the disposal of the ego. In this respect a suggestion by Hartmann (1950, 1955) that anticathectic energies derive from the aggressive drives and are incompletely neutralized, in that they still retain characteristics of their origin, is of interest. It seems possible that unsuccessful or neurotic defences —involving pathological systems of anticathexis—employ energies that are less highly neutralized than those used in the more stable defence-systems necessary for healthy adaptation. If correct, this assumption would lead to the further conclusion that the freeing of anticathectic energies by interpretation and their use in attention-cathexis involves a change in neutralization, thus again furthering adaptation.

We can now consider certain dynamic consequences of interpretation, beginning with the discharge of instinctual energy in recollection. For although verbalization is itself a method of motor discharge in analysis, affective discharge and recollection is encouraged at the expense of motility.

Recollection is assisted by instinctual pressure which is further increased by the frustration imposed by the transference-resistance. That the process of becoming conscious is itself a gratification is suggested by the relief with which it is sometimes accompanied and which is not wholly accounted for by any concomitant discharge of related affect—though relief may also ensue, for example, from the ego's application of reality-testing to emergent phantasy. From the side of the id there is a fractional instinctual discharge in accordance with the pleasure-pain principle and this may be true even when, as is often the case, inter-

pretation does not produce an immediate or dramatic effect.

Interpretation weakens the defences against recollection. Kris (1950) has suggested that the situation that exists in treatment before an interpretation is made is one of incomplete recall and resembles in some degree the historical context in which the relevant memory-traces were laid down. Signs of incomplete recall in the patient's behaviour are then interpreted in a reconstruction of the original event. However, even when recall is not yet possible, recognition may already be accomplished. In recognition a context is established and is facilitated by perception—in this case by perception of the words the analyst uses. Kris concludes by showing that, through this process of recognition, id and superego strivings come to be felt as syntonic with the event concerned, so that 'I know of' is replaced by 'I believe'. He later enlarged these views in his paper on the recovery of childhood memories (Kris, 1956*b*). The common experience that interpretations 'rarely have an immediate and direct effect upon recall' is examined by Loewenstein (1957) in the light of these papers by Kris.

On the other hand, there is no doubt that interpretation can sometimes produce an immediate feeling of certainty in which the patient realizes quite unequivocally that he has gained an important and qualitatively new insight. In 'The Ego and the Id' there is an important passage which seems to throw light on this matter. There Freud (1923, p. 23) suggests that, by the interposition of word-presentations, internal thought-processes are experienced as perceptions. In hypercathecting the process of thinking, the thoughts are themselves perceived as if they came from without, and so carry conviction.

The treatment situation in psychoanalysis must reinforce this process. In such a setting topographical regression has been encouraged and reality-testing relatively suspended. The analyst's words, unquestionably external, add to this conviction, especially if they name correctly an emergent thought, affect or phantasy. On the other hand, the healthy, scrutinizing part of the patient's ego is ready to submit these mental contents to reality-testing, helped by the analyst who also functions as an auxiliary, stable, autonomous ego.

Loewenstein (1956) points out that one of the autonomous ego-functions which the analyst brings to the help of the patient is his role as an additional memory. He considers that the verbalization of memory is a substitute for action, makes the experience of remembering more real by investing it with objective and social reality, and that auditory perception adds a further reality-value. The concept of a representational world has also increased our understanding of the part played by words in reality-assessment and conviction, and is further considered below.

Remembering alone does not replace motility (or instinctual discharge upon the object) in the analytic situation. Drives are also discharged through affect. In analysis we may be dealing with an 'affect-charge' which can receive instinctual cathexis in the same way as an ideational derivative. The affect-charge is also subject to anticathexis and can reach discharge through correct interpretation. Of course, there are affects which operate differently and serve a defensive function; these are signal-affects, of which signal anxiety is one example (Freud, 1926). The problem of the interpretation of affects is in no way different from that of any other psychic content, and their correct naming seems equally important in any form of psychotherapy. This is as true of compound affects (for example, grief, shame, jealousy, despair) as it is of the more direct derivatives of the libidinal and aggressive drives. Unlike recollection, however, discharge is into the interior of the body via secretory and motor pathways. One of the tasks of interpretation is to give the affect a psychic representation which will to some extent replace a silent interior discharge.

Again, Loewenstein (1956) points out that affects must be verbalized as well as experienced; that, furthermore, their connexions

with specific contents must be re-established; and that their verbalization helps to make them both internal and external realities. Further, the experience of the somatic discharge of affect requires the additive of verbalization, which has a binding as well as an expressive function on affects.

In this respect the function of verbalization, whether by patient or analyst, becomes clearer if we make use of a concept which is now, surely, an integral part of structural theory; namely, the representational world. A comprehensive account of this concept, together with some of its historical roots and certain practical applications, has recently been given by Sandler & Rosenblatt (1962). The aspect of this construction which most closely concerns us is the self-representation. This term was suggested by Hartmann (1950) in an attempt to avoid the ambiguity of Freud's use of the word 'ego' to denote both the self and the psychic structure of the same name. Jacobson (1954) pointed out that this concept could be distinguished from that of the ego since ego-formation begins with the child's growing ability to distinguish the self and the object world. The self-representation includes not only the body-image or body-schema in Schilder's sense, but everything that pertains to the self including feelings, behaviour and relationships. A self-representation can be cathected with instinctual energy in the same was an an object-representation, and when this process is ego-syntonic it can reach consciousness or lead to activity; if ego-dystonic, defences against it come into operation.

Words and symbols form part of the representational world and may be linked with object or self-representations. Part of the work of analysis consists, through interpretation, of the modification of distorted representations including those distortions of the self-model which have occurred at the supposed behest of parental introjects. Sandler, Holder & Meers (1963) point out that the 'shape' of a representation is conditioned at any one moment by the varied demands of the id, external reality, and the introjects. It follows that changes in the representations of both the external world and the introjects can, through interpretation, lead to far-reaching modifications of the self-representation.

The correct naming of idea, image or affect —that is, the mental components which the ego organizes into a representational world— is an essential step in bringing them to consciousness. But this is not all. For parts of the self may lack any adequate representation and the provision of the appropriate word may give them such a status for the very first time. Observations made during treatment can be put into words by the analyst (and by the patient), given a representation, and only then become integrated into the patient's model of himself. In passing, we can note, for future use, that words can give such representations not only to the repressed but also to what, until the moment of speaking, has been non-conscious (beyond full awareness, that is, but not dynamically unconscious). This point will be re-examined in discussing 'clarification'.

The representational world also includes that part of the ego-ideal called by Sandler *et al.* (1963) the 'ideal self' and defined by them, from the child's conscious or unconscious point of view, as 'the self I want to be'. For the change brought about by analysis is not just a modification of the superego but also a change in the more enduring aspects of the ideal self and its relation to the self-representation.

A good deal has now been said about the structural aspects of interpretation. However, in discussing the operation of this device from the side of the ego or the side of the id, the impression may have been given that one deals only with id-impulse or ego-defence as such. This, as we know, is not strictly correct since drives may have defensive vicissitudes (as in reaction-formation) and defences show evidence of primary process functioning (as in displacement). Nevertheless, general considerations hold good. In reaction-formation, for example, the drive has already been subject to a defensive process, namely, partial neutralization.

Hartmann, Kris & Loewenstein (1947) have pointed out that id, ego and superego can be regarded as three centres of psychic functioning whose demarcation, independence and energic investment varies at different times. This seems important in conceptualizing the treatment setting in which we make our interpretations. In analysis, for instance, id intrudes into ego in the regressive setting, the autonomous ego detaches itself from the process, and the superego may greatly diminish its area of activity in a situation in which the patient may feel himself to some extent loved and cared for.

Nowadays psychoanalytic psychology must take into account the adaptive point of view. The strengthening of the autonomous ego in treatment and the increase in the secondary autonomy of processes which, while once defensive, have now lost their instinctual cathexes means that, through analysis, the patient's adaption to his internal and external circumstances may be altogether more realistic. The metapsychology of treatment must include the study of the patient's adaptation to the minimal requirements of the treatment-situation. For all our greatly increased knowledge of instinctual life, the fate it meets with and the psychic formations it encounters, no analyst today can afford to ignore adaptation to reality. It is, in the end, what all the fuss is about.

IV. Some practical applications

Since this paper is concerned with metapsychology and only incidentally with techniques, this discussion will not be extensive. The main points which concern us are, I hope, implicit in what has been said.

If, in psychotherapy, we aim to 'make the unconscious conscious' in any appreciable way, we must try to provide a setting in which the necessary psychological changes can occur when interpretations are given. Some of these requirements can be met irrespective of whether the patient is treated on a couch or in a chair, individually or in a group. For example, there is nothing inherent in any of these varied settings which, from the patient's viewpoint, would prevent his partial identification with the analyst in his observing function and therefore his bringing to bear autonomous ego-functions in self-scrutiny. Equally, he may bring to the treatment the same 'transference-readiness' experienced by anyone who has any severe disturbance in his current object-relations. Again, unless the analyst's manner is cold and indifferent, the patient can still experience, through his awareness of the analyst's understanding and tolerance, a new source of narcissistic supplies which may allow sufficient mitigation of superego function to permit both a useful examination of some of his conflicts and an increased ability to tolerate unwelcome thoughts and impulses. Furthermore, since he also externalizes the sadistic aspects of his superego, he may, through the educative function of psychotherapy, find that any resulting modification of that structure is not necessarily transient.

From the analyst's viewpoint certain therapeutic requirements can also be met. In all these situations he works with words. He can, theoretically, name the word-presentations appropriate to those derivatives which seem capable of entry into consciousness. He can also, if he is in touch with the patient's feelings, correctly name the affects the patient experiences. Lastly, there need be nothing in a setting for brief techniques to hinder any attempt to show the patient the realities of his situation; indeed, in this respect, the advantage may sometimes lie with the modified technique.

So far this list, incomplete and relatively random though it is, appears to give impressive support for a theoretical vindication of interpretation in the modified psychotherapies. But, if the aim really *is* to make the unconscious conscious, we come to a difficulty implicit in the economic point of view. For, in trying to dissolve anticathexes, assistance, in formal psychoanalysis, comes from the patient's id. This instinctual striving, mani-

festing its pressure towards discharge through increasingly remote derivatives, is directed towards the analyst since, in the transference, the analyst has taken the place of the infantile object on which the drive was originally fixated. This striving is augmented by the regressive nature of the transference-situation and the resulting reinforcement of drive-energy at the initial fixation-point. Furthermore, to make the appropriate interpretation at the right time, to name the defence or the impulse against which it is constructed, the therapist must be able to see both sides of the conflict. This is likely to be easier in a situation where secondary-process functioning is less absolute and the operation of the primary process more evident. It is difficult to see how this can be done in the absence of regression and without the use of the basic rule. Finally, even if it could be achieved, the disposal of a minor system of anticathexis is merely a step and 'working through' must still follow its protracted and wilful course. All these conditions presuppose the existence of a transference-neurosis.

Since a transference-neurosis implies that a transference-resistance will be added to other resistances, its presence in some forms of psychotherapy is not an unmixed blessing. However, at this juncture I want to anticipate a question which may be present in the minds of those who do not wittingly encourage this state of affairs and who, working only with spontaneous transference, nevertheless find that their patients acquire valuable insights. If the removal of anticathexes, in any systematic way, is as difficult as this paper seems to suggest, can it be that there are some useful insights which are not wholly dependent on this process?

Everyday experience confirms that this is so, and that changes occur which cannot be lightly dismissed as due to suggestion. To begin with, there are technical devices other than interpretation which can help to increase self-awareness. One of these, familiar to therapist and layman alike and the effects of which are not necessarily superficial, is the measure which Devereux (1951) has called 'confrontation'. Essentially, this consists in presenting to the patient his own words or actions in a form which does not readily allow him to escape their implications. It does not, in itself, communicate anything new to the patient. In this sense, confrontation forms a part of every psychotherapeutic procedure and is often a necessary preliminary to interpretation in analysis. But it seems doubtful if it could be made the sole basis of an insight-therapy even though, as every good neighbour knows, its judicious use can be very telling.

A further contribution to our understanding of non-interpretative devices which yet promote insight has been made by Bibring (1954) in developing the concept of 'clarification' first formulated by Carl Rogers (1942). By 'clarification' Rogers meant 'getting the patient to see more clearly', a process he contrasted with interpretation. Bibring has removed some of the obscurities from this definition, and gives examples of the process which include: showing the patient that his use of the word 'fatigue' refers to his depression; pointing out character attitudes; and the elucidation of a reality-situation by showing the patient the subjective nature of his predicament. Clarification may of course precede interpretation in analysis.

If clarification does not involve the removal of anti-cathexes what is its economic basis? Here we can make use of a suggestion first made by Kris (1950), namely, that there are varying degrees of hypercathexis and that phantasy production or thinking may be invested with a degree of attention-cathexis which may not be sufficient to attain consciousness. I suggest that, in clarification, the analyst's verbalization and the patient's discussion of it may sufficiently increase the hypercathexis of non-conscious material to bring it to awareness and conviction. In this way such a procedure would make the *Pcs.* conscious, though it would not demonstrate the *Ucs.* roots of the *Pcs.* derivatives.

In groups we are faced with different problems brought about largely by group-identifi-

cations and by different dynamic and structural conditions. Nevertheless, the distinction between clarification and interpretation still applies. Incidentally, a successful group-interpretation requires that, for each individual member, accessible systems of anticathexis are in roughly similar states. The same condition does not hold for clarification.

The economic difference between the two procedures can be stated very shortly. In clarification, increase in hypercathexis comes from freely available ego-energies; in interpretation, from anticathexis. In the one process, insight is into the non-conscious; in the other, into the repressed. Clinically the effect of the latter may not be immediate, no doubt because the process is so often fractional. But every diminution of anticathexis not only contributes to the fund of energy freely available to the ego but also lessens the degree of hypercathexis required to bring the repressed material into consciousness.

In this connexion the notion of a representational world is of some assistance. In clarification, the hypercathexis provided by the appropriate word-presentation gives an aspect of the patient's self a representation for the first time. The patient's conceptual model of himself is thereby enlarged.

In analysis, we provide conditions in which the patient can experience a temporary regression, but the moment we begin to speak—the moment we use the vocative—we invite him to look at himself, to see what he is doing; and in that very moment we direct our appeal to his autonomous ego. In the very act of beginning our interpretation we invite him to abandon his regression; and, indeed, unless he is able to do so, he will not make very much sense of what we have to tell him. In other words, there is an alternation between regression on the one hand and self-observation on the other. The patient, while regressed, tries to follow the basic rule, but the moment he begins to listen he abandons it. At one moment he is, so to speak, immersed in his representational world and actively thinking himself into it. He is not merely thinking aloud; and it may be a technical error to treat, in brief psychotherapy, the patient's continuous communications as if they were necessarily of the same order as the thought-sequences of the analytic hour, modified as these are by the primary process and formal and topographical regression. This alternation between regression on the one hand and a form of reality-testing on the other raises for psychoanalysis the problem of frequency and regulation; for psychotherapy, the question is whether it can occur at all and, if so, how it can be controlled.

Briefly, then, the vital choice to be made when undertaking psychotherapy is whether —and to what extent—to allow a transference-neurosis to develop and so to bring about a controlled regression in the service of the treatment. Factors governing this choice do not concern us here. However, once a decision to work with a transference-neurosis is made, a treatment setting must be organized and decisions taken on such important matters as, for example, the choice of a chair or couch, frequency and duration of sessions, and projected length of treatment. This, in itself, raises a difficulty since, once the transference-neurosis develops, the length of treatment, as in analysis, may be unpredictable. Again, while one may confidently decide on a 'focal aim', the drift of the patient's material may simply refuse to co-operate with that intention. Finally, the whole question is enormously complicated by the use of the basic rule in brief techniques with its implicit attempt to stimulate an ego-regression when a parallel regression of instinct (in terms of the analyst-as-object) may not have occurred. Furthermore, while instinctual regression may be less deep when the patient sits in a chair, and perhaps less intensely experienced in more widely spaced sessions, the use of these devices in conjunction with free-association may increase the patient's frustration and encourage acting-out.

All these are proper matters for the analytical psychotherapist to consider. To discuss them further would take us beyond our

present course of inquiry since our main concern is to establish criteria by which we can determine what is, and what is not, interpretation. Nevertheless, I venture the opinion that, provided he makes disciplinary use of his theoretical basis, the analytical psychotherapist has at his disposal a flexibility of technique which can meet a variety of situations and purposes. Indeed, we need to speak of 'wild' psychotherapy in the same way that we speak of 'wild' psychoanalysis, in each case implying psychological treatment uninformed by anything other than the most superficial acquaintance with psychoanalytic theory.

Sterba (1948) has given a good illustration of the kind of flexibility I have in mind. He describes how a useful once-weekly treatment relationship between a patient and a social-worker became disturbed by negative transference-feelings consequent on a new situation which arose when, in response to a request by the patient, the social worker interviewed the patient's sister. The crisis was resolved with the correct interpretation of the negative transference. Sterba's point was that, in a situation where the social-worker was not primarily treating the patient by transference interpretation, such an intervention became urgent when the transference threatened to interfere with the therapy. The former working relationship could then be resumed.

On this clinical note I will stop. For it seems to me to underline the need for clinical work to be understood in terms of psychoanalytic theory, whatever the technique in question. Both for psychoanalysis and psychotherapy, the greatest danger of all is, surely, the divorce of theory and practice.

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